STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: ALABAMA

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*Forms Provided

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**Via HCFA PITN MCD-4-92
*Forms Provided

STATE PLAN UNDER TITLE XIX

OF THE SOCIAL SECURITY ACT

MEDICAL ASSISTANCE PROGRAM

HCFA-AT-80-38 (BPP)
MAY 22, 1980

Medicaid Administration

State Name: Alabama

OMB Control Number: 0938-1148

Transmittal Number: AL - 17 - 0005

State Plan Administration Designation and Authority — A1

42 CFR 431.10

Designation and Authority

State Name: Alabama

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Alabama Medicaid Agency

Type of Agency:

- ○ Title IV-A Agency
- ◉ Health
- ○ Human Resources
- ○ Other

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

Executive Order Number 83, Governor Letter 12/09/1988

The single state agency supervises the administration of the state plan by local political subdivisions.

○ Yes ◉ No

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

○ Yes ◉ No

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

(•) Yes ( ) No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 02/01/17

The type of responsibility delegated is (check all that apply):

- [ ] Determining eligibility
- [x] Conducting fair hearings
- [ ] Other

Name of state agency to which responsibility is delegated:

Office of Attorney General

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

Alabama Medicaid Agency (Medicaid) delegates the authority to conduct administrative fair hearings to the Office of Attorney General. Hearings are conducted by Administrative Law Judges (ALJs) who are employees of the Office of Attorney General. Upon completion of the testimony and receipt of documents or briefs, the ALJ will make a written finding of fact and conclusions of law in the matter. Based upon these findings, the ALJ will make a written recommendation and provide such recommendation, along with the completed record and all documentary evidence, to the Agency within 30 days of the conclusion of the hearing or such shorter or longer time as agreed to by the parties involved in the case. The Commissioner of Medicaid will concur or non-concur with the conclusion of law of the ALJ. Fair hearing decisions may be appealed in circuit court.

The Office of Attorney General acknowledges and agrees in writing that he/she will act as a neutral and impartial decision maker on behalf of Medicaid in adjudicating all Medicaid cases and that he/she will comply with all applicable federal and state laws, rules, regulations, policies, and guidance governing the Medicaid program.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

Medicaid retains oversight of the State Plan and has a process to monitor the entire appeals process, including the quality and accuracy of the recommendation made by the Office of Attorney General .

Medicaid ensures that every applicant and beneficiary is informed, in writing, of the fair hearing process and how to contact Medicaid and how to obtain information about fair hearings from Medicaid.

Medicaid ensures that the Office of Attorney General complies with all Medicaid related federal and state laws, regulations, and policies.

Medicaid has a written agreement with the Office of Attorney General that defines the roles and responsibilities.

Remove

Date waiver granted (MM/DD/YY): 10/26/17

The type of responsibility delegated is (check all that apply):

- ☐ Determining eligibility
- ☒ Conducting fair hearings
- ☐ Other

Name of state agency to which responsibility is delegated:

Alabama State Personnel Department

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

Alabama Medicaid Agency (Medicaid) delegates the authority to conduct all Medicaid fair hearings to the Alabama State Personnel Department. Hearings are conducted by Administrative Law Judges (ALJs) who are employees of the State Personnel Department. Upon completion of the testimony and receipt of documents or briefs, the ALJ will make a written finding of fact and conclusions of law in the matter. Based upon these findings, the ALJ will make a written recommendation and provide such recommendation, along with the completed record and all documentary evidence, to the Agency within 30 days of the conclusion of the hearing or such shorter or longer time as agreed to by the parties involved in the case. The Commissioner of Medicaid will issue fair hearing decisions. The Medicaid agency will review the recommended fair hearing decision issued by the ALJ only with respect to conclusions of law, including interpretations of state or federal policy. Fair hearing decisions may be appealed in circuit court.

The State Personnel Department acknowledges and agrees in writing that he/she will act as a neutral and impartial decision maker on behalf of Medicaid in adjudicating all Medicaid cases and that he/she will comply with all applicable federal and state laws, rules, regulations, policies, and guidance governing the Medicaid program.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

The Medicaid agency retains oversight of the State Plan and has a process to monitor the entire appeals process, including the quality and accuracy of the recommendation made by the Alabama State Personnel Department.

The Medicaid agency ensures that every applicant and beneficiary is informed, in writing, of the fair hearing process and how to contact the Medicaid agency and how to obtain information about fair hearings from the Medicaid agency.

The Medicaid agency ensures that the Alabama State Personnel Department complies with all Medicaid related federal and state laws, regulations, and policies.

The Medicaid agency has a written agreement with the Alabama State Personnel Department that defines the roles and responsibilities of the agencies.

Add

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

☒ The Medicaid agency

☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☒ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

☒ The Medicaid agency

☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

☒ Medicaid agency

☐ Title IV-A agency

☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

☒ Medicaid agency

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Name of entity: HHS Appeals Entity

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

○ Yes ◉ No

State Plan Administration
Organization and Administration
A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

Alabama Medicaid Agency is the administrative unit that is responsible for administering the Alabama Medicaid Program.

Functions of the Alabama Medicaid Agency include the following responsibilities:
(a) develop rules and regulations for administering the Medicaid program to comply with the State Plan for Medical Assistance;

(b) perform utilization and medical review activities;
(c) prepare budgets;
(d) establish contracts with medical providers to render care to Medicaid recipients;
(e) monitor the provision of medical care and payment of claims;
(f) conduct investigation and audit functions;
(g) collect and analyze data and publish statistical and management reports pertinent to the program;
(h) make reimbursement collections from liable third parties;
(i) provide information about the program;
(j) provide for the training of staff members;
(k) conduct fair hearings;
(l) assure that claims for the medical care of Medicaid recipients are properly paid;
(m) perform eligibility functions and,
(n) establish criteria for admission to Long Term Care facilities to include evaluation and certification of recipients.

The Administrative Services Division responsibilities include Information Technology, Project Management, and Financial Administration. Information Technology is responsible for all of the Agency's IT components to include MMIS, Computer Operations, Beneficiary Software, Claims Software, IT Security and Quality Assurance. Project Management is responsible for all of the Agency's procurement activities to include coordination of ITBs, RFIs, RFPs and overseeing projects throughout the Agency. Financial Administration is responsible for Administrative Services activities such purchasing, records management, mail room operations, and risk management; Budgeting/Reporting; Financial Operations such as Accounts payable and receivable and Fiscal Agent Policy and System management which is responsible for contract monitoring, system support and policy management.

The Health System Division is responsibilities include Managed Care, Medical Services, Health Information Technology and Analytic Unit. Managed Care is responsibilities include Maternity Care, LTC Quality Improvements. Medical Services responsibilities include Institutional Services and Clinics/Mental Health. Analytic Unit is responsible for Quality metrics and Business Analytic/Statistical Support. Health Information Technology is responsible for Health Information Exchange and meaningful Use.

The Program Administration Division includes Communications, Program Integrity, Third Party Liability, Provider Audit/ Reimbursement, Long term Care, Clinical Services and Support and Non Emergency Transportation. Program Administration responsibilities include Investigations, Provider Review, Quality Control and Recipient Review. Third Party Liability responsibilities include Payment Review, Health Insurance and Benefit Recovery. Long Term Care is responsible for Project Development, Provider/Recipient Services, Long Term Care Specialized Waiver and Program Management. Clinical Services and Support is responsible for Pharmacy Administrative Services, Pharmacy Clinical Support, Drug Rebate and Medical and Quality Review.

Beneficiary Services Division includes East and West Customer Services, Technical Support and Policy and Training. East and West Customer Services is responsible for eligibility determinations for beneficiaries in all program areas other than those conducted by the Department of Human Resources (DHR). Technical Support is responsible for Interagency Coordination, Statistical Reporting and Recipient Subsystems. Policy and Training is responsible for development and issuance of Policy for all program areas, Operational Readiness/Applications Assisters and Training for all Beneficiary Services staff and Application Assisters. The Alabama Medicaid Agency determines eligibility for the following programs: Poverty level pregnant women, children under age 19, Plan First Waiver, Breast and Cervical Cancer Program (BCC), Nursing Home Program, Hospital Program, Post Hospital Extended Care (PEC) Program, Institutional Care Facility for the Mentally Retarded (ICF-MR) Program, Home and Community Based Waiver for Person with Intellectual Disabilities (ID), Elderly and Disabled Waiver, State of Alabama Independent Living (SAIL) Waiver, HIV/AIDS Waiver, OBRA Waiver, Living at Home (LAH) Waiver, Technology Assisted Waiver for Adults, Alabama Community Transition (ACT) Waiver, Newborn Program, Program of All-Inclusive Care for the Elderly (PACE), SSI related groups: Widow/Widower, Disabled Adult Child, Retroactive SSI, Children of SSI Mothers, Continuous (PICKLE), Grandfathered Children. Medicare related groups: Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Income Individuals and Qualified Disabled Working Individuals, Others: Emergency Services for Aliens, Department of Youth Services (DYS) Children; and Parent and Other Caretaker Relative (POCR); and Child Health Insurance Program (CHIP).

Eligibility determinations are performed by state merit staff.

Human Resources Division is responsible for overseeing all Human resources activities for the Agency.

Governmental Affairs Division is responsible for coordination and communications with the Legislature and other entities.

Office Of General Counsel Division is responsible for representing the Agency for all hearings and appeals.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The Governor of the State of Alabama is elected for a four-year term by the people of the State. Under the Constitution of Alabama of 1901, the supreme executive power of the State is vested in this office which is a component of the Executive Branch. In directing the affairs of Alabama, the Governor carries out responsibilities authorized by the Constitution. Included in this authorization are: See that the laws are faithfully executed, convene the Legislature under extraordinary circumstances, provide information on the state of the government (including the submission of budgetary requirements) to the Legislature; veto legislation to which he objects; serve as chairman of numerous committees and boards; make appointments to boards, committees and departments.

The Alabama Department of Public Health determines eligibility for individuals for the following programs: Nursing Home Program, Hospital Program, Post Hospital Extended Care (PEC) Program, Institutional Care Facility for the Mentally Retarded (ICF-MR) Program, Home and Community Based Waiver for Person with Intellectual Disabilities (ID), Elderly and Disabled Waiver, State of Alabama Independent Living (SAIL) Waiver, HIV/AIDS Waiver, OBRA Waiver, Living at Home (LAH) Waiver, Technology Assisted Waiver for Adults, Alabama Community Transition (ACT) Waiver, Newborn Program, Program of All-Inclusive Care for the Elderly (PACE), poverty level pregnant women, children under age 19, Parent and Other Caretaker Relatives (POCR), Plan First Waiver SSI related groups: Widow/Widower, Disabled Adult Child, Retroactive SSI, Children of SSI Mothers, Continuous (PICKLE), Grandfathered Children. Medicare related groups: Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Income Individuals and Qualified Disabled Working Individuals.

Public Health Social Workers responsible for determining eligibility are housed within Medicaid offices and are supervised by Medicaid. Health Insurance Assistants and Health Insurance Specialists are housed within the Child Health Insurance Program (CHIP). ADPH is the administering Agency for Alabama's CHIP.

The Office of Attorney General and Alabama State Personnel Department are responsible for conducting all Agency hearings and appeals for both eligibility and services on behalf of applicants and beneficiaries. The Office of Attorney General and the Alabama State Personnel Department issue findings and recommended fair hearing decisions. These decisions are reviewed by the Medicaid Commissioner, who issues final fair hearing decisions.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ◉ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Remove

Type of entity that determines eligibility:

- (•) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ( ) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The Department of Human Resources is the state's Title IV-A agency and determines eligibility for individuals for the following programs: Foster children and children who receive State or Federal Adoption Assistance.
1. Eligibility Staff and Functions
a. Financial Support Worker I and II (DHR)

This is a DHR position which determines eligibility for foster children and children who receive State or Federal Adoption Assistance, MAGI related groups, Parent and Other Caretaker Relatives (POCR), and Emergency Services.

2. Supervisory and Administrative Staff

a. Administrative Assistant I, II and III (DHR)
Duties for these positions include filing, sorting mail, typing documents, proofreading documents, making copies, greeting and directing the public, taking telephone messages, posting/logging transmittal records or making simple calculations.

b. Program Supervisor (DHR)

This position provides supervision to previous DHR classifications and performs eligibility determination oversight.

Remove

Type of entity that determines eligibility:

- ( ) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- (•) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ( ) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The Federally- Facilitated Marketplace (FFM) will be determining eligibility for Medicaid for groups of individuals whose income eligibility is determined based on MAGI income methodology and who apply through the FFM. The FFM will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a specific eligibility group, determining cost-sharing (if applicable), or assigning a benefit package-functions that will be performed by the single state agency.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ◉ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The HHS appeals entity will conduct Medicaid fair hearings for individuals whose Medicaid eligibility has been determined and found ineligible for Medicaid by the Federally-facilitated Marketplace (FFM). These will be individuals whose income eligibility is determined based on MAGI income methodology and who applied for health coverage through the FFM.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

○ Yes ◉ No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

- ○ Counties
- ○ Parishes
- ○ Other

Are all of the local subdivisions indicated above used to administer the state plan?

○ Yes ◉ No

Remove

Names of local subdivisions used to administer the state plan:

Description of the staff and functions of the local subdivisions (provide only once if they all have the same description. If they do not, provide as many descriptions as needed, and indicate for each description to which local subdivision it applies.):

Add

State Plan Administration Assurances A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☑ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

☑ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☑ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

☑ The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

State: Alabama

Citation 1.4 State Medical Care Advisory

42 CFR 431.12 (b)

There is an advisory committee to the Medicaid Agency in accordance with and meeting all the requirements of 42 CFR 431.12.

Tribal Consultation

In order to comply with the Tribal Consultation requirement of Section 1902(a)(73) of the Social Security Act and Federal Regulation, 42 CFR 431.12(b), Alabama Medicaid Agency will seek the advice on a regular on-going basis from designees of Indian health programs whether operated by the Indian Health Service (HIS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHICA). Section 2107 (e) (I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). In Alabama the CHIP program is administered through the Alabama Department of Public Health. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

The Poarch Band of Creek Indians is the only federally recognized Indian Tribe in the state of Alabama.

The State will advise either per certified letter or by an expedited process of email and fax on matters related to Medicaid and for consultation on all State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals, proposals for demonstration projects and any other changes that would affect the Tribe prior to submission to CMS.

It will be the standard operating procedure of the Alabama Medicaid Agency to give 30 day written notice to the Tribal Chair prior to any submission to CMS. This notice will be sent by certified mail. The Tribe will be allowed 30 calendar days from the date of the receipt of the notice to respond.

Revision: HCFA-AT-80-38 (BPP) May 22, 1980 AL-15-006

State: Alabama

Citation 1.4 State Medical Care Advisory

42 CFR 431.12 (b)

An expedited request which is defined as the result of a State or Federal law change or any change that will be of detriment to recipients will be implemented per the program area with direct responsibility for submission of the SPA. In the event of the determined need for an expedited process, the procedure is as follows: The Agency will send the required information via fax to 251-368-1026, after which an e-mail will be sent to the Tribal Chair notifying the Tribe of the fax transmission. The Tribe will be given 10 calendar days from the date of the fax confirmation to respond.

On April 18, 2011 a letter was mailed to Mr. Buford Rolin of the Poarch Creek Indians requesting approval of written notification with a response time of 30 calendar days from the date of receipt of the notice. On May 04, 2011 the State received written confirmation from the Poarch Creek Indians that they were in agreement with the terms described in the letter dated April 18, 2011.

On May 24, 2011, Nikki Scott called the office of Buford Rolin and spoke with him and received verbal approval of the expedited process in the event of a quick submission to CMS for SPA's. On May 26, 2011 a letter was faxed to Buford Rolin's office relative to the process of notifying the Tribe in the event of an expedited State Plan Amendment, waiver proposal, waiver extension, waiver amendment, waiver renewal or proposal for demonstration projects prior to submission to CMS verifying that in addition to the verbal approval, the agency needed written approval as well. Mr. Rolin signed the letter and faxed it back to Nikki Scott's office. The Agency will send the required information via fax to 251-368-1026, after which an e-mail will be sent to Buford Rolin at tlancaster@pci-nsn.gov notifying the Tribe of the fax transmission. 10 calendar days from the date of the fax confirmation will be given to respond.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994

State/Territory: Alabama

Citation 1.5 Pediatric Immunization Program

1928 of the Act 1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

NOV 30 1994

TN No. AL-94-19 Approval Date _____ Effective Date October 1,1994
Supersedes
TN No. New

Revision: HCFA-PM-94-3 (MB)
APRIL 1994

State/Territory: Alabama

Citation

1928 of the Act

g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

_____State Medicaid Agency

__X__State Public Health Agency

NOV 30 1994

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ALABAMA

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Revision: HCFA-PM- (MB)

State/Territory: Alabama

Citation		
42 CFR 435.914 1902(a)(34) of the Act	2.1(b) (1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act	(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and 1920 of the Act	_____(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

State/Territory: ALABAMA

Citation		
1902(a)(55) of the Act	2.1(d)	The Medicaid Agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the Title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the AFDC form except as permitted by HCFA instructions.

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid
(Continued)

1902(e)(13) of the Act

X (e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determinations made before February 4, 2009.

(1) The Express Lane option is applied to:

___ Initial determinations

___ Redeterminations

X Both

(2) A child is defined as an individual under age:

X 19

___ 20

___ 21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

The Alabama Department of Human Resources in the administration of the Supplemental Nutritional Assistance Program (SNAP) and the Temporary Assistance for Needy Families (TANF) Program

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid
(Continued)

(4) The following components of Medicaid eligibility are determined under the Express Lane option:
Net income information, family size and income disregards from SNAP or TANF will be used to determine Medicaid eligibility. The following summarizes differences in methodology:

Required for Budget Unit: For Medicaid- only the child and legal parents living in the home;
For SNAP-the child and other individuals who purchase food or prepare meals for home consumption;
For TANF-only the child and the legal parent living in the home

Net Income Limit: For Medicaid -100% of the federal poverty level (FPL) for children age 6 and older and 133% of the FPL for children under 6;
For SNAP- 100% of the FPL for children under 19;
For TANF - 11% of the FPL for children under age 19

Income Disregards: For Medicaid-$90 of wages per wage earner, amount of allowable deductions for self-employment (SE) operating expenses, up to $175 for child care expenses for children age 2 and older and up to $200 for children under 2, and $30 and 1/3 of income for one year for individuals covered under Section 1931; For SNAP- Earned income deduction of 20% of gross wages, SE deduction of 40% of gross proceeds, amount of actual dependent care expenses, medical deduction for a disabled child with expenses in excess of $35, amount of court-ordered child support paid, shelter cost deduction, standard deduction for household size;
For TANF – Earned income deduction of 20% of gross wages, SE deduction of 40% of gross proceeds, and amount of dependent care expenses

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid
(Continued)

(5) Check off and describe the option used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXI:

__ (a) Screening threshold established by the Medicaid agency as:

___ (i) __ percentage of the FPL which exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points: specify_____; or

___ (ii) ____ percentage of the FPL (describe how this reflects the value of any differences between income methodologies of Medicaid and the Express Lane agency: _____); or

___ (b) Temporary enrollment pending screen and enroll.

_X_ (c) State's regular screen and enroll process for CHIP.

___(6) The State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's Medicaid enrollment.

___ (7) The State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ALABAMA

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

/_/ Mandatory categorically needy and other required special groups only.

/_/ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

/X/ Mandatory categorically needy, other required special groups, and specified optional groups.

/_/ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State: ALABAMA

Citation

435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: ALABAMA

Citation	2.4 Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State: ALABAMA

Citation	2.5	Disability
42 CFR 435.121, 435.540(b) 435.541		All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.~~14~~ 13 b. of ATTACHMENT 2.2-A of this plan.

* Via. PITN-MCD-4-92

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ALABAMA

Citation
42 CFR
435.10 and
Subparts G & H

1902(a)(10)(A)(i)
(III), (IV), (V),
and (VI),
1902(a)(10)(A)(ii)
(IX), 1902(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(l)
and (m),
1905(p) and (s),
1902(r)(2),
and 1920
of the Act

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: ALABAMA

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ALABAMA

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, as defined in 42 CFR 440.165 are provided to the extent that nurse-midwives are authorized to practice under State law or regulation. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

/ / Not applicable. Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Alabama

Citation

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/ /(iv) Service for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10)(F)(VII)

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10(A)(ii)(IX) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: ALABAMA

Citation	3.1(a)(1)		Amount, Duration, and Scope of Services: Categorically Needy (Continued)
		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	____	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act		(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	____	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: ALABAMA

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, Subpart B

(a)(2) Medically needy.

42 CFR 440.220 *

/ This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act

(i) If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

* (42 CFR 440.120 and 440.160)

/ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act

(ii) Prenatal care and delivery services for pregnant women.

* Via - HCFA-PI TN-MCD-4-92

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Alabama

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/ /(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

/ / Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42CFR 440.140, 440.150, 440.160*
1902(a)(10)(C)
Subpart B
1902(a)(20) and (21) of the Act

/ /(vii) Services in an institution for mental diseases for individuals over age 65.

/ /(viii) Services in an intermediate care facility for the mentally retarded.

(ix) Inpatient psychiatric services for individuals under age 21.

* VIA - HCFA-FITN-MCD-4-92

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: ALABAMA

Citation			3.1(a)(2)4 Amount, Duration, and Scope of Services: Medically Needy (Continued)
1902(e)(9) of the Act	___	(ix)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1905(a)(23) and 1929	___	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Superseded by HCFA-PM-93-5 May 1993 93-29

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Alabama

Citation 3.1 Amount, Duration, and Scope of Services (continued)

1902(a)(10)(E)(I) and clause (VII) of the matter following (F), and 1905(p)(3) of the Act	(a)	(3)		Other Required Special Groups: Qualified Medicare Beneficiary (QMB) Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)	(4)	(i)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10) (e)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iii) and 1905 (p)(3)(A)(ii) of the Act			(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(I) 1905(p)(3)(A)(ii), and 1933 of the Act			(iii)	Other Required Special Groups: Qualifying Individuals - 1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv) (I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(II) 1905(p)(3)(A)(iv)(II), 1905(p)(3) of the Act			(iv)	Other Required Special Groups: Qualifying Individuals - 2 The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv) (II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Alabama

Citation 3.1 Amount, Duration, and Scope of Services (continued)

1925 of the Act (a) (5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Sec. 245A(h) of the Immigration and Nationality Act (a) (6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immirgration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they-

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a) (6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ALABAMA

Citation			Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902(a) and 1903(v) of the Act		(iii)	Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act		(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	17	(a)(8) *	Preseumptively Eligible Pregnant Women ~~Ambulatory prenatal care for pregnant~~ women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act		(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

TN No. AL-91-36
Supersedes TN No. New
Approval Date 10-2-92
Effective Date 01/01/92
HCFA ID: 7982E

* VIA HCFA-PITN-MCD-4-92

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State: Alabama

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 /_/ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**

42 CFR 440.240 and 440.250

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4), and 1932 of the Act

(a)(10) Comparability of Services

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

/_/ (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

** Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

Revision: HCFA - Region VI
November 1990

State Alabama

Citation
42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

Section 1905(a)(4)(A) of Act (Sec. 4211(f) of P.L. 100-203).

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes

☐ Not applicable. The State plan does not provide for nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

☐ Yes, to all

☐ Yes, to individuals age 21 or over; nursing facility services are provided.

☐ Yes, to individuals under age 21; nursing facility services are pro

☐ No; nursing facility services are not provided.

☒ Not applicable; the medically needy are not included under this plan

To be Superseded by 93-29

Citation	3.1 Amount, Duration, and Scope of Services (Continued)	
42 CFR 431.53	(c)(1)	Assurance of Transportation Provision is made for assuring necessary transportation or recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.
42 CFR 483.10	(c)(2)	Payment for Nursing Facility Services The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (3) (8) (i).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation	3.1(d)	Methods and Standards to Assure Quality of Services
42 CFR 440.260 AT-78-90		The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	Family Planning Services The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

Revision: HCFA-PM-87-5 (BERC)
January 1989

OMB No.: 0938-0193

State/Territory: ALABAMA

Citation
42 CFR 441.30
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

|__| Yes.

|__| No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

|X| Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

|__| No.

|X| Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: ALABAMA

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act, P.L. 99-509 (Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

/ / 30 consecutive days;

/ / ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/ / Yes. The requirements of section 1902(e)(9) of the Act are met.

/X/ Not applicable. These services are not included in the plan, except as covered as a referral from an EPSDT Screening.

STATE ALABAMA

Citation 3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2A, by the following method:

_X_ Group premium payment arrangement for Part A

___ Buy-In agreement for

___ Part A _X_ Part B

_X_ *The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

*Medicaid covers Medicare HMO premiums, coinsurance, and deductibles through a capitation payment to the Medicare HMO.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Alabama

Citation 3.2 Coordination of Medicaid with Medicare and Other Insurance (continued)

1902(a)(10)(E)(ii) and 1905(s) of the Act

(ii) Qualified Disabled and Working Individuals (QDIW)

The Medicaid Agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in items A.26 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act

(iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii) and 1933 of the Act

(iv) Qualifying Individual-1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act

(v) Qualifying Individual-2 (QI-2)

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premiums attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Alabama

Citation 3.2 Coordination of Medicaid with Medicare and Other Insurance (continued)

1843(b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

x All individuals who are: a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d) (2).

__ Individuals receiving Title II or Railroad Retirement benefits.

__ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

___ The Medicaid agency pays insurance premium for medical or any other type of remedial care to maintain third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

State: Alabama

tation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a),and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

___ For the entire range of services available under Medicare Part B.

_X_ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State ALABAMA

Citation		
42 CFR 441.252 AT-78-99	3.4	Special Requirements Applicable to Sterilization Procedures All requirements of 42 CFR Part 441, Subpart F are met.

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State: ALABAMA

Citation 1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

/X/ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

/ / Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

/ / Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/ / Medical or remedial care provided by licensed practitioners.

/ / Home health services.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ALABAMA

Citation 3.5 Families Receiving Extended Medicaid Benefits
(Continued)

- [ ] Private duty nursing services.
- [ ] Physical therapy and related services.
- [ ] Other diagnostic, screening, preventive, and rehabilitation services.
- [ ] Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- [ ] Intermediate care facility services for the mentally retarded.
- [ ] Inpatient psychiatric services for individuals under age 21.
- [ ] Hospice services.
- [ ] Respiratory care services.
- [ ] Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ALABAMA

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) /_/ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

/_/ 1st 6 months /_/ 2nd 6 months

/_/ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

/_/ 1st 6 mos. /_/ 2nd 6 mos.

(d) /_/ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

/_/ Enrollment in the family option of an employer's health plan.

/_/ Enrollment in the family option of a State employee health plan.

/_/ Enrollment in the State health plan for the uninsured.

/_/ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ALABAMA

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/_/ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

/_/ Enrollment in an eligible health maintenance organization (HMO) that has an enrollment of less than 50 percent of Medicaid recipients who are not recipients of extended Medicaid.

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/_/ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: ALABAMA

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State ALABAMA

Citation	4.2 Hearings for Applicants and Recipients
42 CFR 431.202 AT-79-29 AT-80-34	The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

Revision: HCFA-AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST1987

State/Territory: ALABAMA

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0
MARCH 1987

State/Territory: ALABAMA

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), ~~(g), (h) and (k).~~ (i), (h), (j), and (k).

/ / Yes.

/X/ Not applicable. The State has an approved Medicaid Management Information System (MMIS)

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: ALABAMA

Citation	4.5 Medicaid Agency Fraud Detection and Investigation Program
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

State: **ALABAMA**

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act	X The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. ___ The State is seeking an exception to establishing such program for the following reasons:
Section 1902(a)(42)(B)(ii)(I) of the Act	X The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	Place a check mark to provide assurance of the following: X The State will make payments to the RAC(s) only from amounts recovered. X The State will make payments to the RAC(s) on a contingent basis for collecting overpayments. The following payment methodology shall be used to determine State payments to Medicaid RACs for recovered overpayments (e.g., the percentage of the contingency fee): A contingency fee of 11.5% for overpayments collected.
Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	___ The State attests that if the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register, the State will only submit for

Citation	
	FFP up to the amount equivalent to that published rate. ____ The following payment methodology shall be used to determine State payments to Medicaid RACs for underpayments: ____ The State will submit a justification seeking to pay the Medicaid RAC(s) a contingency fee higher than the highest contingency fee rate paid to Medicare RACs as published in the Federal Register.
Section 1902 (a)(42)(B)(ii)(III) of the Act	_X_ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	_X_ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902 (a)(42)(B)(ii)(IV)(bb) of the Act	_X_ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act	_X_ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

New: HCFA-PM-99-3
JUNE 1999

State: Alabama

Citation

42 CFR 431.51
AT 78-90
46 FR 48524
48 FR 23212
1902(a)(23)
P.L. 100-93
of the Act
(Section 8(f))
P.L. 100-203
(Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

Section 1902(a)(23)
of the Social
Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or

Section 1932(a)(1)
Section 1905(t)

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 4420.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is State Board of Health

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): State Board of Health

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The State Board of Health _____ (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

☐ Yes, as listed below:

☒ Not applicable. Similar services are not provided to other types of medical facilities.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ALABAMA

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

/X Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Citation			
1902 (a)(58)			
1902(w)	4.13	(e)	For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law Or court decision exist regarding advance directives.

Revision: HCFA-PM-91-10(MB)
DECEMBER 1991

State/Territory: Alabama

Citation		
42 CFR 431.60 42 CFR 456.2 50 FR 15312 1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	4.14	Utilization/Quality Control (a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

_____ Directly

_X_ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —

(1) Meets the requirements of §434.6(a):

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1932(c)(2) and 1902(d) of the ACT, P.L. 99-509 (section 9431)

A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E for each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation .

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: ALABAMA

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/ / All hospitals (other than mental hospitals).

/ / Those specified in the waiver.

/X/ No waivers have been granted.

Revision: HCFA-PM-85-7 (BERC) OMB NO.: 0938-0193
JULY 1985

State/Territory: ALABAMA

Citation
42 CFR 456.2
50 FR 15312

4.14. (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals. /

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

☐ All mental hospitals.

☐ Those specified in the waiver.

☐ No waivers have been granted.

☐ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: ALABAMA

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/ / All skilled nursing facilities.

/ / Those specified in the waiver.

/X/ No waivers have been granted.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: ALABAMA

OMB NO. 0938-0193

Citation
42 CFR 456.400
through
42 CFR 456.438

4.14 /X/ (e) The Medicaid agency meets the requirements of 42 CFR 456 Subpart F, for control of the Utilization of Nursing Facility and ICF/MR services. Utilization review in facilities is provided through:

/X/ Facility-base review or contract with a professional review organization.

/__/ Direct review by personnel of the medical assistance unit of the State agency.

/__/ Personnel under contract to the medical assistance unit of the State agency.

/__/ Utilization and Quality Control Peer Review Organizations.

/__/ Another method as described in ATTACHMENT 4.14-A.

/__/ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/__/ Not applicable. Nursing Facility services are not provided under this plan.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: Alabama

Citation		
	4.14	Utilization/Quality Control (Continued)
42 CFR 438.356(e)		For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.
42 CFR 438.354 42 CFR 438.356(b) and (d)		The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.
	___	Not applicable.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Alabama

Citation
42 CFR 456.2
AT-78-90

4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases

All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

☐ Not applicable with respect to intermediate care facility services; such services are not provided under this plan.

☐ Not applicable with respect to services for individuals age 65 or over in institutions for mental diseases; such services are not provided under this plan.

☐ Not applicable with respect to inpatient psychiatric services for individuals under age 22; such services are not provided under this plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

Citation (s)
42 CFR 433.36 (c)
1902(a) (18) and
1917(a) and (b) of
The Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

_X_ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917 (a) of the Act and regulations at 42 CFR 433.36 (c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

_____ The State imposes liens on real property on account of benefits incorrectly paid.

_X_ The State imposes TEFRA liens 1917 (a) (1) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State Plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

_____ The State imposes liens on both real and personal property of an individual after the individual's death.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

_X_ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a) (1) (B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

-X_ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

Recoveries for all approved medical assistance, for Medicaid recipients age 55 and over, except for Medicare cost-sharing as specified at 4.17 (b) (3-continued).

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1,2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

1917(b)1(C) (4) __X__ If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

Revision: HCFA-AT-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Alabama

Citation 42 CFR 447.51 through 447.58

4.18 Recipient Cost Sharing and Similar Charges

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[ ] Age 19

[ ] Age 20

[ ] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 938-

State/Territory: Alabama

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[X] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[ ] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Citation 4.18(b) (Continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

/_/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

/X/ 18 or older

/_/ 19 or older

/_/ 20 or older

/_/ 21 or older

/_/ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: ALABAMA

Citation
42 CFR 447.51
through 447.58

4.18(b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/ / Not applicable. There is no maximum.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: ALABAMA

Citation		
1916(c) of the Act	4.18(b)(4) /_/	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5) /_/	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6) /_/	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ALABAMA

Citation

4.18(c) /7 Individuals are covered as medically needy under the plan.

42 CFR 447.51 through 447.58

(1) /7 An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

/7 Age 19

/7 Age 20

/7 Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

evis **Revision:** HCFA-PM-91- 4 (BPD) **OMB No.:** 0938-
AUGUST 1991

State/Territory: ALABAMA

Citation 4.18 (c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

☐ Not applicable. No such charges are imposed.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ALABAMA

Citation

447.51 - 447.58

4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

/ / Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

/ / 18 or older

/ / 19 or older

/ / 20 or older

/ / 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: ALABAMA

Citation 4.18(c)(3) (Continued)

447.51 through 447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

/ / Not applicable. There is no maximum.

State/Territory: ALABAMA

Citation

4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act
1902(e)(7)

(a) The Medicaid Agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

/X/ Inappropriate level of care days are covered and are paid under the State Plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1816(v)(1)(G) of the Act with limitations.

/__/ Inappropriate level of care days are not covered.

Revision: HCFA-PM-93-6 (MB)
AUGUST 1993

State/Territory: Alabama

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements (1) Section 1902(a)(13)(e) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(c) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub.45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Section 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance. *except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

*VIA HCFA-PITN-MCD-4-92

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation		
42 CFR 447.40 AT-78-90	4.19(c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

Revision: HCFA - Region VI
November 1990

State/Territory: _____

Citation
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141
Section 1902(a)(13)(A) of Act (Section 4211 (h)(2)(A) of P.L. 100-203).

4.19 (d)

(1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for nursing facility services and intermediate care facility services for the mentally retarded.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for nursing facility services and intermediate care facility services for the mentally retarded.

(2) The Medicaid agency provides payment for routine nursing facility services furnished by a swing-bed hospital.

[X] At the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.

[ ] At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

[ ] Not applicable. The agency does not provide payment for NF services to a swing-bed hospital.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation		
42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: ALABAMA

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State ALABAMA

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

State: ALABAMA

Citation

42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: ALASKA

Citation		
1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physican to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: HCFA-PM-94-8 (MB)
October 1994

State/Territory: ALABAMA

Citation		
4.19	(m)	Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program
1928(c)(2)(C)(ii) of the Act	(i)	A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.
	(ii)	The State:
		___ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.
		___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.
		_X_ sets a payment rate below the level of the regional maximum established by the DHHS Secretary.
		___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.
		The State pays the following rate for the administration of a vaccine:
1926 of	(iii)	Medicaid beneficiary access to immunization is assured through the following methodology:
		A comparison of the Medicaid fees for administration of pediatric vaccines to the administration fees paid by a major insurance company within the State.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 447.25(b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

State ALABAMA

Citation	4.21	Prohibition Against Reassignment of Provider Claims
42 CFR 447.10(c) AT-78-90 46 FR 42699		Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Alabama

Citation		
	4.22 Third Party Liability	
42 CFR 433.137	(a)	The Medicaid agency meets all requirements of:
	(1)	42 CFR 433.138 and 433.139.
	(2)	42 CFR 433.145 through 433.148.
	(3)	42 CFR 433.151 through 433.154.
1902(a)(25)(H) and (I) of the Act	(4)	Sections 1902(a)(25)(H) and (I) of the Act.
42 CFR 433.138(f)	(b)	Attachment 4.22-A --
	(1)	Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
42 CFR 433.138(g)(1)(ii) and (2)(ii)	(2)	Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
42 CFR 433.138(g)(3)(i) and (iii)	(3)	Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and
42 CFR 433.138(g)(4)(i) through (iii)	(4)	Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

State/Territory: ALABAMA

4.22 Third Party Liability (Continued)

Citation

42 CFR 433.139 (b) (3) (ii) (A) X

(c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) Attachment 4.22-B specifies the following:

42 CFR 433.139(b) (3) (ii) (C)

(1) The method used in determining a provider's compliance with the third party billing requirements at 433.139(b)(3)(ii)(c).

42 CFR 433.139(f)(2)

(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3)

(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20

(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

1902(a)(25)(I)

(f) The Medicaid Agency ensures that regulations are in effect that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules. These regulations comply with the provisions of section 202 of the Consolidated Appropriations Act, 2022.

State: Alabama

itation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

___ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s)--

_____

_____

___ Other appropriate agency(s) of another State--

_____

_____

_X_ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

___ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

_X_ The State provides methods for determining cost effectiveness on Attachment 4.22-C.

Revision: HCFA-AT-84-2 (BERC)
01-84

State ALABAMA

Citation
42 CFR Part 434.4
48 FR 54013

4.23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

☐ Not applicable. The State has no such contracts.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1984-421-858:1049

Revision: HCFA-AT-80-62 (BPP)
August, 1980

State ALABAMA

Citation
42 CFR 442.10
and 442.100
AT-78-90
AT-79-18
AT-80-25
AT-80-34
AT-80-61
52FR32544

4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services.

With respect to skilled nursing and intermediate care facilities, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

☐ Not applicable to intermediate care facilities; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Revision: HCFA-PM- (MB)

State/Territory:_____

tation

1927(g) 4.26 Drug Utilization Review Program
42 CFR 456.700

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

-Appropriate
-Medically necessary
-Are not likely to result in adverse medical results

1927(g)(1)(a)
42 CFR 456.705(b) and
456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

-Potential and actual adverse drug reactions
-Therapeutic appropriateness
-Overutilization and underutilization
-Appropriate use of generic products
-Therapeutic duplication
-Drug disease contraindications
-Drug-drug interactions
-Incorrect drug dosage or duration of drug treatment
-Drug-allergy interactions
-Clinical abuse/misuse

1927(g)(1)(B)
42 CFR 456.703
(d) and (f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

-American Hospital Formulary Service Drug Information
-United States Pharmacopeia-Drug Information
-American Medical Association Drug Evaluations

Revision: HCFA-PM- (MB)

State/Territory: _____

Citation		
1927(g)(1)(D) 42 CFR 456.703(b)	D.	DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in: ___ Prospective DUR _X_ Retrospective DUR
1927(g)(2)(A) 42 CFR 456.705(b)	E.1.	The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.
1927(g)(2)(A)(i) 42 CFR 456.705(b),)-(7)	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: -Therapeutic duplication -Drug-disease contraindications -Drug-drug interactions -Drug-interactions with non-prescription or over-the-counter drugs -Incorrect drug dosage or duration of drug treatment -Drug allergy interactions -Clinical abuse/misuse
1927(g)(2)(A)(ii) 42 CFR 456.705 (c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.
1927(g)(2)(B) 42 CFR 456.709(a)	F.1.	The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: -Patterns of fraud and abuse -Gross overuse -Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Revision: HCFA-PM- (MB)

STATE/TERRITORY: _____

Citation	
1927(g)(2)(c) 42 CFR 456.709(b)	F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: -Therapeutic appropriateness -Overutilization and underutilization -Appropriate use of generic products -Therapeutic duplication -Drug-disease contraindications -Drug interactions -Incorrect drug dosage/duration of drug treatment -Clinical abuse/misuse
1927(g)(2)(D) 42 CFR 456.711	3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
1927(g)(3)(A) 42 CFR 456.716(a)	G.1. The DUR program has established a State DUR Board either: _X_ Directly, or ___ Under contract with a private organization
1927(g)(3)(B) 42 CFR 456.716 (A) AND (B)	2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: - Clinically appropriate prescribing of covered outpatient drugs. - Clinically appropriate dispensing and monitoring of covered outpatient drugs. - Drug use review, evaluation and intervention. - Medical quality assurance.
1927(g)(3)(C) 42 CFR 456.716(d)	3. The activities of the DUR Board include: -Retrospective DUR, -Application of Standards as defined in section 1927(g)(2)(C), and -Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

Revision: HCFA-PM-Section 4.26 (MB) OMB

STATE / TERRITORY Alabama

Citation			
1927 (g) (3) (C) 42 CFR 456.711 (a)-(d)		G.4.	The interventions include in appropriate instances: - Information dissemination - Written, oral and electronic reminders - Face-to-Face discussions - Intensified monitoring/ review of prescribers/ dispensers
1927 (g) (3) (D) 42 CFR 456.712 (A) and (B)		H.	The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)		I.	Claim Review Limitations - Prospective safety edits on opioid prescriptions to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness. - Prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent on opioids prescription to limit the daily morphine equivalent (as recommended by clinical guidelines). - Retrospective reviews on opioid prescriptions exceeding these above limitations on an ongoing basis. - Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis. Programs to monitor antipsychotic medications to children. Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines. Fraud and abuse identification: The DUR/Lock-In program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.
1927 (h) (1) 42 CFR 456.722	X	I.1	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claim management system to perform on-line: - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacies, etc. applying for and receiving payment.
1927 (g) (2) (A) (i) 42 CFR 456.705 (b)	X	2.	Prospective DUR is performed using an electronic point of sale drug claims processing system.
1927 (j) (2) 42 CFR 456.703 (c)		J.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation		
42 CFR 431.115(c) AT-78-90 AT-79-74	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1 (BPD)
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

Citation	4.28 Appeals Process
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919 (e)(7) of the Act; P.L. 100-203 (Sec. 4211(c).	(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
	(b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer of discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

New: HCFA-PM-99-3
JUNE 1999

State: Alabama

Citation

1902(a)(4)(C) of the Social Security Act
P.L. 105-33

4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the Social Security Act
P.L. 105-33
1932(d)(3)
42 CFR 438.58

The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: ALABAMA

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

/ / The agency, under the authority of State law, imposes broader sanctions.

per HCFA 9/11/99

Citation		
	(b)	The Medicaid agency meets the requirements of –
1902(p) of the Act	(1)	Section 1902(p) of the Act by excluding from participation—
	(A)	At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under Title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808	(B)	An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –
	(i)	Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
	(ii)	Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610	(2)	An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438,610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c).

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: ALABAMA

Citation	
1902(a)(39) of the Act P.L. 100-93 (sec. 8(f))	(2) Section 1902(a)(39) of the Act by--
	(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
	(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
	(c) The Medicaid agency meets the requirements of--
1902(a)(41) of the Act P.L. 96-272, (sec. 308(c))	(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and
1902(a)(49) of the Act P.L. 100-93 (sec. 5(a)(4))	(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: ALABAMA

Citation

455.103
44 FR 41644
1902(a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940
through 435.960
52 FR 5967

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: ALABAMA

Citation
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

Revision: HCFA-PM-88-10 (BERC) SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: ALABAMA

Citation 1137 of the Act

P.L. 99-603 (sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/ / The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/ / The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/ / Total waiver

/ / Alternative system

/ / Partial implementation

Revision: HCFA-PM-90-2 (BPD)
JANUARY 1990

OMB No.: 0938-0193

State/Territory: ALABAMA

Citation	4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation
1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))	(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.
	/ / Not applicable to intermediate care facilities; these services are not furnished under this plan.
	XX (b) The agency uses the following remedy(ies):
	(1) Denial of payment for new admissions.
	(2) Civil money penalty.
	(3) Appointment of temporary management.
	(4) In emergency cases, closure of the facility and/or transfer of residents.
1919(h)(2)(B)(ii) of the Act	/ / (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.
1919(h)(2)(F) of the Act	/ / (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:
	/ / (1) Public recognition.
	/ / (2) Incentive payments.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

AL-95-20

STATE/TERRITORY: ALABAMA

Citation 4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

STATE/TERRITORY: ALABAMA

Citation

(c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919(h)(2)(D) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 §1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

- X (1) Termination
- X (2) Temporary Management
- X (3) Denial of Payment for New Admissions
- X (4) Civil Money Penalties
- X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
- X (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

AL-95-20

STATE/TERRITORY: ALABAMA

Citation

42 CFR §488.406(b) §1919(h)(2)(B)(ii) of the Act.

(ii) ___ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

___ (1) Temporary Management
___ (2) Denial of Payment for New Admissions
___ (3) Civil Money Penalties
___ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
___ (5) State Monitoring

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR §488.303(b) §1910(h)(2)(F) of the Act.

(e) ___ State Incentive Programs

___ (1) Public Recognition
___ (2) Incentive Payments

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ALABAMA

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91- 10 (BPD)
DECEMBER 1991

State/Territory: State of Alabama

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38		Nurse Aide Training and Competency Evaluation for Nursing Facilities
		(a)	The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	X	(b)	The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
	X	(c)	The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
		(d)	The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
	___	(e)	The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	___	(f)	The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

Citation	
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request. (h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met. (i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met. (j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met. (k) For program reviews other than the initial review, the State visits the entity providing the program. (l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

State/Territory: State of Alabama

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(m)	The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
		(n)	The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
		(o)	The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
		(p)	The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
	X	(q)	The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
		(r)	The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

State/Territory: State of Alabama

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(s)	When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
		(t)	The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
		(u)	The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
		(v)	The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
		(w)	Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
	X	(x)	The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
		(y)	The State has a standard for successful completion of competency evaluation programs.

State/Territory: State of Alabama

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	___	(cc)	The State includes home health aides on the registry.
	___	(dd)	The State contracts the operation of the registry to a non State entity.
	___	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	___	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Revision: HCFA-PM-93-1 (BPD)
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

Citation
Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c); P.L. 101-508 (Sec. 4801(b).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 CFR 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State Plan" the cost of NF services to individuals who are found not to require NF services.

X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1 (BPD)
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

4.39 (Continued)

X (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels or severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determination it applies in ATTACHMENT 4.39-A.

HCFA-PM-92-3 (HSQB) OMB No.:
APRIL 1992

State/Territory: ALABAMA

Citation Sections		
	4.40 Survey & Certification Process	
1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1)(B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). **Attachment 4.40-A** describes the survey and certification educational program.
1919(g)(1)(C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. **Attachment 4.40-B** describes the State's process.
1919(g)(1)(C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1)(C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1)(C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

sion: HCFA-PM-92-3 (HSQB) OMB No:
APRIL 1992

State/Territory: ALABAMA

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. **Attachment 4.40-C** describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

ion: HCFA-PM-92- 3 (HSQB) OMB No:
APRIL 1992

State/Territory: ALABAMA

1919(g)(2) (D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. **Attachment 4.40-D** describes the State's programs.
1919(g)(2) (E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2) (E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2) (E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
9(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. **Attachment 4.40-E** describes the State's complaint procedures.
1919(g)(5) (A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5) (B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5) (C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5) (D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

State/ Territory: Alabama

PROPOSED SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation

Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

__X__ The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

National Governors Association
ENCLOSURE A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

4.46 Provider Screening and Enrollment

Citation	The State Medicaid agency gives the following assurances:
1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152	
42 CFR 455 Subpart E	PROVIDER SCREENING __X__ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X__ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__ Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X__ Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420 REACTIVATION OF PROVIDER ENROLLMENT

__X__ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422 APPEAL RIGHTS

__X__ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

SITE VISITS

42 CFR 455.432 __X__ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

CRIMINAL BACKGROUND CHECKS

42 CFR 455.434 __X__ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

FEDERAL DATABASE CHECKS

42 CFR 455.436 __X__ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

NATIONAL PROVIDER IDENTIFIER

42 CFR 455.440 __X__ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

SCREENING LEVELS FOR MEDICAID PROVIDERS

42 CFR 455.450 __X__ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

APPLICATION FEE

42 CFR 455.460

__X__ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

42 CFR 455.470

__X__ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State ALABAMA

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

5.2 [Reserved]

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation		
42 CFR Part 432, Subpart B AT-78-90	5.3	Training Programs; Subprofessional and Volunteer Programs The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State ALABAMA

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Revision: HCFA-AT-~~81-~~ 82-10 (BPP)

State ALABAMA

Citation
42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

TN # 82-10
Supersedes
TN # 76-6

Approval Date 6-29-82 Effective Date 5-24-82

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ALABAMA

Citation
42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

[X] State funds are used to pay all of the non-Federal share of total expenditures under the plan.

[ ] There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: ALABAMA

SECTION 7 - GENERAL PROVISIONS

Citation	7.1	Plan Amendments
42 CFR 430.12(c)		The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: ALABAMA

Citation	7.2	Nondiscrimination
45 CFR Parts 80 and 84		In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap. The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: ALABAMA

Citation	7.3	Maintenance of AFDC Efforts
1902(c) of the Act	/X/	The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
August 1991

State: Alabama

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid Agency will provide opportunity for the Governor to review State Plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

X Not applicable. Submission is not required because the Governor's designee is the head of the Medicaid Agency.

_____ Does not wish to review any plan material.

_____ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

The Governor's Office
(Designated Single State Agency)

Date: June 2, 2004

(Title)

Carol. A. Herrmann
Commissioner
Alabama Medicaid Agency



(Signature)

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Alabama Medicaid is requesting, for any state plan submitted related to the COVID-19 emergency declared by the President or Secretary, the ability to give tribal notice at the time the State Plan is filed with CMS.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. __X__ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Alabama Medicaid suspends Medicaid copayments for all items and services for all eligibility groups during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. __X__ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

In addition to the use of an interactive audio and video telecommunication system which permits two-way communication between the distant site physician and the recipient, during the emergency, physicians and other licensed practitioners covered by the state plan may perform evaluation and management services, therapies, and other medically necessary services as appropriate utilizing telephone communications.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

Location (list published location): _____

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. _____ Are not otherwise paid under the Medicaid state plan;

    b. _____ Differ from payments for the same services when provided face to face;

    c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X_ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. ____ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Section A – Eligibility

1. ____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

   Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. __X__ The agency makes the following adjustments to benefits currently covered in the state plan:

   Alabama Medicaid is suspending the requirements in Attachment 3.1-A, Page 9.24 for ambulance providers so emergency ambulance service destinations are not restricted and prior authorization is not required for nonemergency services.

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

      Please describe.

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

   Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. ____ Other:

Describe methodology here.

State/Territory: Alabama_

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. _____ Are not otherwise paid under the Medicaid state plan;

b. _____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

a. _____ The individual's total income

b. _____ 300 percent of the SSI federal benefit rate

c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

State/Territory: Alabama_

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _X_ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Alabama Medicaid is requesting, for any state plan submitted related to the COVID-19 emergency declared by the President or Secretary, the ability to give tribal notice at the time the State Plan is filed with CMS.

Section A – Eligibility

1. ____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020 and 4/7/2020, and does not supersede anything approved in those SPAs.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020 and 4/7/2020, and does not supersede anything approved in those SPAs.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020 and 4/7/2020, and does not supersede anything approved in those SPAs.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ___ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020 and 4/7/2020, and does not supersede anything approved in those SPAs.

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. _____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. _____ Other:

Describe methodology here.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020 and 4/7/2020, and does not supersede anything approved in those SPAs.

Increases to state plan payment methodologies:

2. _X_ The agency increases payment rates for the following services:

Increase payments for nursing facilities

a. _X_ Payment increases are targeted based on the following criteria:

Increase in per diem rates for all nursing homes due to increases in cost associated with staffing, supplies, social distancing standards and other factors.

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. _X_ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_X_ By the following factors:

Increase rate uniformly by a $20.00 per diem add on payment for all nursing home facilities due to the COVID-19 state of emergency. *An additional cleaning fee reimbursement for the Medicaid proportion of actual costs incurred for facilities with COVID-19 patients or staff.* *Increased payments will be applicable for dates of service during the period of March 1, 2020 through the end of the national emergency.*

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020 and 4/7/2020, and does not supersede anything approved in those SPAs.

Add on payments will be netted against total reported cost in determining future rate setting.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. _____ Are not otherwise paid under the Medicaid state plan;

    b. _____ Differ from payments for the same services when provided face to face;

    c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

    Describe telehealth payment variation.

    d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020 and 4/7/2020, and does not supersede anything approved in those SPAs.

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020 and 4/7/2020, and does not supersede anything approved in those SPAs.

7.4.A. Rescissions to the State's Disaster Relief Policies for the COVID-19 National Emergency

1. Effective February 1, 2022, the Alabama Medicaid Agency rescinds the election at item E.2.a and E.2.b of section 7.4 (approved on April 13, 2020 in SPA AL-20-0006) of the disaster state plan amendment (SPA), which provided a $20.00 per diem add-on uniformly for all nursing home facilities and an additional cleaning fee for the Medicaid portion of the actual costs incurred for facilities with COVID-19 patients or staff. The $20.00 add-on has been incorporated in the actual per diem rates under the regular state plan effective February 1, 2022 based upon a full year of COVID-19 cost data included in each facilities' June 30, 2021 cost report. The $20.00 add-on was not offset in deriving the February 1, 2022 per diem rates. The cleaning fee cost has also been absorbed in the cost reports. Providers were notified of their individual rates effective February 1, 2022 in accordance with normal rate setting process outlined in the regular state plan.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

The flexibilities described in this SPA shall be implemented throughout the duration of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, and 4/13/20, and does not supersede anything approved in those SPAs.

c. __X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Alabama Medicaid is requesting, for any state plan submitted related to the COVID-19 emergency declared by the President or Secretary, the ability to give tribal notice at the time the State Plan is filed with CMS.

Section A – Eligibility

1. __X__ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

COVID 19 Testing for the Uninsured: The state intends to cover the 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) group effective March 18, 2020 which includes those affected by COVID 19. There is no maximum income or resource limit. The individual must be uninsured.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

   Less restrictive resource methodologies:

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, and 4/13/20, and does not supersede anything approved in those SPAs.

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, and 4/13/20, and does not supersede anything approved in those SPAs.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, and 4/13/20, and does not supersede anything approved in those SPAs.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the state-wideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, and 4/13/20, and does not supersede anything approved in those SPAs.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. ____ Other:

Describe methodology here.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, and 4/13/20, and does not supersede anything approved in those SPAs.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, and 4/13/20, and does not supersede anything approved in those SPAs.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. ____ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, and 4/13/20, and does not supersede anything approved in those SPAs.

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

7.4.A. Rescissions to the State's Disaster Relief Policies for the COVID-19 National Emergency

Effective March 18, 2020, the agency rescinds the election at A.1. of section 7.4 (approved on May 11, 2020 in SPA Number AL-20-0007) of the state plan to furnish medical assistance to the optional eligibility group described at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/2020, and 5/11/2020, and does not supersede anything approved in those SPAs.

c. __X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Alabama is requesting, for any state plan submitted related to the COVID-19 emergency declared by the President or Secretary, the ability to give tribal notice at the time the State Plan is filed with CMS.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/2020, and 5/11/2020, and does not supersede anything approved in those SPAs.

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/2020, and 5/11/2020, and does not supersede anything approved in those SPAs.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. _____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/2020, and 5/11/2020, and does not supersede anything approved in those SPAs.

b. _____ Other:

Increases to state plan payment methodologies:

2. __X__ The agency increases payment rates for the following services:

20% Increase in per diem rates for all COVID-19 diagnosis patients for hospital inpatient stays due to increases in cost associated with staffing, supplies, social distancing standards and other factors.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. __X__ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

__X__ By the following factors:

20% increase in per diem rates for COVID -19 related diagnosis effective March 1, 2020 through the end of the emergency period.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/2020, and 5/11/2020, and does not supersede anything approved in those SPAs.

Increase is consistent with Medicare emergency related increase for COVID-19 patients

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. _____ Are not otherwise paid under the Medicaid state plan;

   b. _____ Differ from payments for the same services when provided face to face;

   c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. _____ The individual's total income

   b. _____ 300 percent of the SSI federal benefit rate

   c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/20, 5/11/20, and 5/27/20, and does not supersede anything approved in those SPAs.

c. ___X___ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Alabama is requesting the ability to give tribal notice at the time the State Plan **Amendment** is filed with CMS.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

   Income standard: _____

   -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

   Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/20, 5/11/20, and 5/27/20, and does not supersede anything approved in those SPAs.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/20, 5/11/20, and 5/27/20, and does not supersede anything approved in those SPAs.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a. _____ The agency uses a simplified paper application.

   b. _____ The agency uses a simplified online application.

   c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

   a. _____ All beneficiaries

   b. _____ The following eligibility groups or categorical populations:

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/20, 5/11/20, and 5/27/20, and does not supersede anything approved in those SPAs.

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/20, 5/11/20, and 5/27/20, and does not supersede anything approved in those SPAs.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. _____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/20, 5/11/20, and 5/27/20, and does not supersede anything approved in those SPAs.

b. _____ Other:

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please describe.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/20, 5/11/20, and 5/27/20, and does not supersede anything approved in those SPAs.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. _____ Are not otherwise paid under the Medicaid state plan;

   b. _____ Differ from payments for the same services when provided face to face;

   c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __X__ Other payment changes:

The State intends to allow code D1999 (Unspecified preventive procedure) to be billed and reimbursed at $20.00 to allow for reimbursement of PPE and cleaning supplies PPE that are necessary for dental offices to provide treatment to recipients due to the COVID-19 pandemic.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. _____ The individual's total income

   b. _____ 300 percent of the SSI federal benefit rate

   c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/20, 5/11/20, and 5/27/20, and does not supersede anything approved in those SPAs.

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

This SPA is in addition to the Alabama Disaster Relief SPAs approved on 4/6/2020, 4/7/2020, 4/13/20, 5/11/20, and 5/27/20, and does not supersede anything approved in those SPAs.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Alabama Medicaid is requesting the ability to give tribal notice at the time the State Plan Amendment is filed with CMS.

Section A – Eligibility

1. ____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

   Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ___ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. _____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. _____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. __X__ The agency increases payment rates for the following services:

Increase payments for nursing facilities

a. __X__ Payment increases are targeted based on the following criteria:

A supplemental payment for all nursing homes due to increases in cost associated with staffing, supplies, social distancing standards and other factors.

b. Payments are increased through:

i. __X__ A supplemental payment or add-on within applicable upper payment limits:

A supplemental payment totaling $50 million allocated to each Nursing home based on pro-rata share of Medicaid patient days during the period from July 1, 2021 through June 30, 2022. The amount so determined for each Nursing Home will be paid in equal installments monthly beginning September 1, 2022 through June 30, 2023.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

___ By the following factors:

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. _____ Are not otherwise paid under the Medicaid state plan;

b. _____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

a. _____ The individual's total income

b. _____ 300 percent of the SSI federal benefit rate

c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

N/A

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Alabama Medicaid state plan, as described below:

Alabama Medicaid is requesting, for any state plan submitted related to the COVID-19 emergency declared by the President or Secretary, the ability to give tribal notice at the time the State Plan is filed with CMS.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

   Less restrictive resource methodologies:

This SPA is in addition to all previously approved Disaster Relief SPAs and does not supersede anything approved in those SPAs.

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

This SPA is in addition to all previously approved Disaster Relief SPAs and does not supersede anything approved in those SPAs.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. __X__ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Alabama is requesting they waive any signature requirements for the dispensing of drugs during the Public Health Emergency.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. _____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. _____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

   a. _____ Payment increases are targeted based on the following criteria:

This SPA is in addition to all previously approved Disaster Relief SPAs and does not supersede anything approved in those SPAs.

Please describe criteria.

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. _____ Are not otherwise paid under the Medicaid state plan;

b. _____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. _____ Ancillary cost associated with the originating site for telehealth is

incorporated into fee-for-service rates.

ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. _____ The individual's total income

   b. _____ 300 percent of the SSI federal benefit rate

   c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

This SPA is in addition to all previously approved Disaster Relief SPAs and does not supersede anything approved in those SPAs.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

7.4.B. Temporary Extension to the Disaster Relief Policies for the COVID-19 National Emergency

Effective May 12, 2023 until June 30, 2023, the agency temporarily extends the following elections(s) of section 7.4 (approved 04/12/2021 in SPA number AL-22-0014) of the state plan:

Section E – Payments

Increases to state plan payment methodologies:

1. X The agency increases payment rates for the following services:

Increase payments for nursing facilities

a. X Payment increases are targeted based on the following criteria:

A supplemental payment for all nursing homes due to increases in cost associated with staffing, supplies, social distancing standards and other factors.

b. Payments are increased through:

i. X A supplemental payment or add-on within applicable upper payment limits:

A supplemental payment totaling $50 million allocated to each Nursing home based on pro-rata share of Medicaid patient days during the period from July 1, 2021 through June 30, 2022. The amount so determined for each Nursing Home will be paid in equal installments monthly beginning September 1, 2022 through June 30, 2023.

7.4.B. Temporary Extension to the Disaster Relief Policies for the COVID-19 National Emergency

Effective May 12, 2023 until September 30, 2024, the agency temporarily extends the following elections(s) of section 7.4 (approved 04/02/20 in SPA number AL-20-0004) of the state plan:

Section C – Premiums and Cost Sharing

1. X The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Alabama Medicaid suspends Medicaid copayments for all items and services for all eligibility groups until September 30, 2024.

7.4.B. Temporary Extension to the Disaster Relief Policies for the COVID-19 National Emergency

Effective May 12, 2023 until May 31, 2023, the agency temporarily extends the following elections(s) of section 7.4 (approved 04/02/20 in SPA number AL-20-0004) of the state plan:

Section D – Benefits

Telehealth:

5. X The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

In addition to the use of an interactive audio and video telecommunication system which permits two-way communication between the distant site physician and the recipient, during the emergency, physicians and other licensed practitioners covered by the state plan may perform evaluation and management services, therapies, and other medically necessary services as appropriate utilizing telephone communications.

THE ATTORNEY GENERAL

STATE OF ALABAMA · MONTGOMERY, ALABAMA 36130

WILLIAM J. BAXLEY
ATTORNEY GENERAL

GEORGE L. BECK
DEPUTY ATTORNEY GENERAL
L. B. SULLIVAN
EXECUTIVE ASSISTANT
WALTER S. TURNER
CHIEF ASSISTANT ATTORNEY GENERAL
TOM CORK
CONFIDENTIAL ASSISTANT
JACK D. SHOWS
CHIEF INVESTIGATOR

June 17, 1977

STATE OF ALABAMA)

MONTGOMERY COUNTY)

C E R T I F I C A T E

I, William J. Baxley, as Attorney General of the State of Alabama, hereby certify that the Governor's Office of the State of Alabama is the single State agency authorized to develop and administer the State plan on a statewide basis, including the authority to make rules and regulations governing the administration of the plan by such agency, for medical assistance to needy people in conformity with Title XIX of the Social Security Act; said Governor's Office having been so designated by the Governor of Alabama in Executive Order Number Eighty-One, issued June 16, 1977.

Certified on this the 17th day of June, 1977, in Montgomery, Alabama.

WILLIAM J. BAXLEY
Attorney General
State of Alabama

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

EXECUTIVE ORDER NUMBER EIGHTY-ONE

WHEREAS, on June 30, 1967, the Governor of Alabama ordered and designated the State Board of Health as the single State agency to develop and administer the State plan for medical assistance to the needy people in conformity with Title XIX of the Social Security Act; and

WHEREAS, it is in the best interest of the citizens of the State of Alabama to change this designation.

NOW, THEREFORE, I, George C. Wallace, as Governor of the State of Alabama do hereby order:

1. That paragraph 2 on page 2 of Executive Order Number 8, promulgated on June 30, 1967, be amended to read as follows:

"2. That the Governors Office is hereby ordered to be the single state agency to develop and administer the State plan for medical assistance to the needy people in confirmity with Title XIX of the Social Security Act."

2. That the remainder of Executive Order Number 8, promulgated June 30, 1967, shall remain in full force and effect.

DONE AND ORDERED THIS 16 DAY OF June 1977.

George C Wallace
GOVERNOR OF THE STATE OF ALABAMA



ATTEST:

Mrs. Agnes Baggett
SECRETARY OF STATE

EXECUTIVE ORDER NUMBER EIGHTY-THREE

WHEREAS, on June 30, 1967, the Governor of Alabama ordered and designated the State Board of Health as the single State agency to develop and administer the State Plan for Medical Assistance in conformity with Title XIX of the Social Security Act, and ordered that the State Department of Pensions and Security determine eligibility for medical assistance under said Plan, and

WHEREAS, on June 16, 1977, the Governor of Alabama amended said June 30, 1967, designation so as to order the Governor's Office to be the single State agency to develop and administer said Plan; and

WHEREAS, it is in the best interest of the citizens of the State of Alabama to change the designation of the agency to determine eligibility under said Plan, and to consolidate in the Governor's Office as the single State agency all of the functions previously designated by the promulgation of Executive Order Number 8 of June 30, 1967, but retain the services of the Department of Pensions and Security in determining eligibility for medical assistance for certain persons:

NOW, THEREFORE, I, George C. Wallace, as Governor

of the State of Alabama, do hereby order:

1. That the Governor's Office, as the single State agency to develop and administer the State Plan for Medical Assistance in conformity with Title XIX of the Social Security Act is also designated as the single State agency to determine eligibility for medical assistance under the said Plan.

2. That Executive Order Number 8 of June 30, 1967, is hereby amended as follows:

(a) The State Department of Pensions and Security is hereby ordered to determine and/or monitor eligibility for medical assistance under the State Plan for Medical Assistance for the following persons:

(1) Those persons whose eligibility is related to the Aid to Families with Dependent Children financial assistance program.

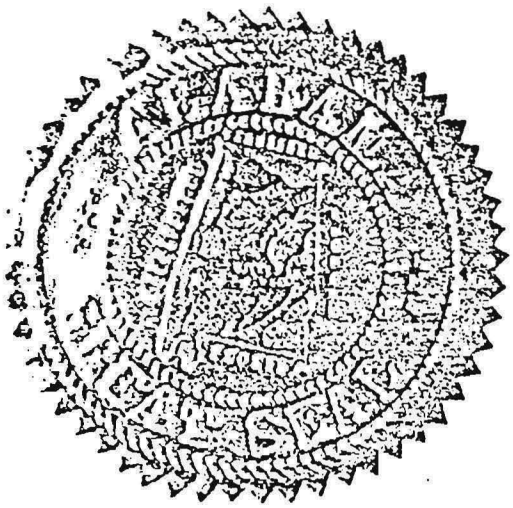
(2) Those persons whose eligibility is related to the state mandatory or optional supplementation program.

(b) The Medical Services Administration is hereby ordered to determine and/or monitor eligibility for medical assistance under the State Plan for all other persons and groups of persons.

3. This Order shall be come effective on October 1, 1977.

DONE AND ORDERED THIS 26th DAY OF October , 1977.

GEORGE C. WALLACE
GOVERNOR



ATTEST:

MRS. Agnes Baggett
SECRETARY OF STATE

EXECUTIVE ORDER NUMBER 38.

WHEREAS, there exists confusion among the general public with regard to Medicaid and Medicare, and

WHEREAS, Medicare is a program of the federal government, administered by the Federal Government, and

WHEREAS, Medicaid is a program administered in the State of Alabama by the Medical Services Administration, and

WHEREAS, the name "Medical Services Administration" does not accurately reflect the operation of that agency, and

WHEREAS, the name "Alabama Medicaid Agency" conforms with the names of agencies with similar functions in the majority of other states,

NOW, THEREFORE, I, Fob James, as Governor of the State of Alabama, under and by virtue of the authority vested in me by law, hereby order and declare that the name of "Medical Services Administration" is changed to "Alabama Medicaid Agency", and that the Commissioner of the Medical Services Administration shall be known as the "Commissioner of Medicaid".

DONE AND ORDERED THIS 2 day of March 1981.

FOB JAMES, Governor

ATTEST:

Secretary of State

EXECUTIVE ORDER NUMBER 8

WHEREAS, on November 19, 1965, the Governor of Alabama designated the State Department of Pensions and Security as the single State agency to administer the medical assistance plan under Title XIX and to supervise its administration in the county departments of pensions and security; and

WHEREAS, the Legislature of Alabama has further authorized and empowered me to give to any State agency by executive order such powers and duties as are not in conflict with the Constitution of Alabama and not specifically prohibited by the existing statutes of Alabama as may be required to implement in Alabama any law, order, rule, regulation, program or plan promulgated by the Federal Government or any agency or instrumentality thereof as may be required in my judgment for the welfare of the people of Alabama (Act No. 60, General Acts of Alabama 1945, p. 60, Title 55, Section 180(2), Code of Alabama 1940); and

WHEREAS, I do specifically find that the Federal Social Security Act requires that the State agency administering Title I (old age assistance) shall make the determination of eligibility for medical assistance under

the plan.

NOW THEREFORE, I as Governor of Alabama do hereby order:

1. THAT the designation heretofore made in the Governor's letter of November 19, 1965, is hereby rescinded.

2. THAT the State Board of Health is hereby ordered to be the single State agency to develop and administer the State plan for medical assistance to the needy people in conformity with Title XIX of the Social Security Act.

3. THAT the State Department of Pensions and Security, through its sixty-seven county departments, is hereby ordered to determine eligibility for medical assistance under the State plan for Title XIX.

Done this the 30th of June, 1967.

LURLEEN B. WALLACE
GOVERNOR OF ALABAMA

ATTEST:

SECRETARY OF STATE

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

GUY HUNT
Governor

CAROL A. HERRMANN
Commissioner

January 13, 1989



Mr. Jerry Royal
Health Care Financing Administration
Post Office Box 2078
Atlanta, Georgia 30301

Dear Mr. Royal:

I am providing you copies of the letter from Governor Guy Hunt appointing Carol A. Herrmann, Commissioner, as his Designee to process State Plan Amendments from this agency.

This action is based on the October 21, 1988 federal regulation as stated in 42 CFR Section 430.12(b)(2)(i) which states "submission is not required if the Governor's designee is the head of the Medicaid Agency."

Please place these copies in your files for future reference concerning State Plan Amendments. Your cooperation is appreciated.

Sincerely,

Theresa M. Beasley

Theresa M. Beasley
Agency Administrative Secretary

TMB:mt

Enclosures

STATE OF ALABAMA

GOVERNOR'S OFFICE

MONTGOMERY 36130

GUY HUNT
GOVERNOR

December 9, 1988

JAN 1989
RECEIVED
REGION IV
HCFA

Ms. Carol A. Herrmann
Commissioner
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, AL 36130

Dear Ms. Herrmann:

Federal regulations require that state Medicaid agencies operate under a federally approved State Plan which reflects the characteristics of the particular state's Medicaid program. Heretofore, there were no exceptions to the requirement in 42 C.F.R. Section 430.12 (b)(1)(i) which states "the Medicaid agency must submit the State plan and State plan amendments to the State Governor or his designee for review and comment before submitting them to the HCFA regional office."

Effective October 21, 1988, federal regulations included an exception to that requirement as stated in 42 C.F.R. Section 430.12 (b)(2)(i). This stated "submission is not required if the Governor's designee is the head of the Medicaid agency."

Since I know that you keep me informed on all significant developments in Medicaid, I am pleased to expedite our administrative actions by naming you as my Designee to process the State Plan Amendments without sending them to my office for review and comment.

If any further action is appropriate, please let me know.

Sincerely,

Guy Hunt

Guy Hunt
Governor

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

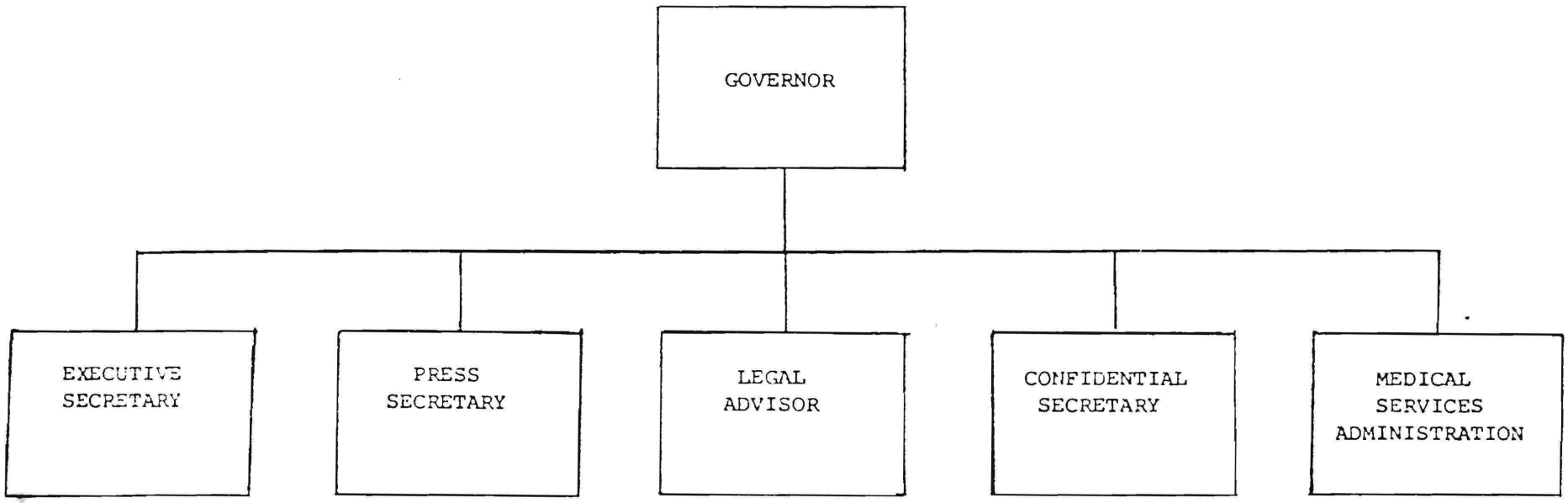
Organization and Functions of the Governor's Office

1. The Governor of the State of Alabama is elected for a four-year term by the people of the State. Under the Constitution of Alabama of 1901, the supreme executive power of the State is vested in this office which is a component of the Executive Branch. An organizational chart of the Governor's Office may be found on page 1.1 of Attachment 1.2-A.

2. In directing the affairs of Alabama, the Governor carries out responsibilities authorized by the Constitution. Included in this authorization are: See that the laws are faithfully executed, convene the Legislature under extraordinary circumstances, provide information on the state of the government (including the submission of budgetary requirements) to the Legislature; veto legislation to which he objects; serve as chairman of numerous committees and boards; make appointments to boards, committees, and departments.

STATE OF ALABAMA

ORGANIZATION OF THE GOVERNOR'S OFFICE



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

Organization and Functions of the Alabama Medicaid Agency

1. Alabama Medicaid Agency is the administrative unit that is responsible for administering the Alabama Medicaid Program. The organizational structure is shown on page 2 of Attachment 1.2-B.

2. Functions of the Alabama Medicaid Agency include the following responsibilities:

   (a) develop rules and regulations for administering the Medicaid program to comply with the State Plan for Medical Assistance;

   (b) perform utilization and medical review activities;

   (c) prepare budgets;

   (d) establish contracts with medical providers to render care to Medicaid recipients;

   (e) monitor the provision of medical care and payment of claims;

   (f) conduct investigation and audit functions;

   (g) collect and analyze data and publish statistical and management reports pertinent to the program;

   (h) make reimbursement collections from liable third parties;

   (i) provide information about the program;

   (j) provide for the training of staff members;

   (k) conduct fair hearings;

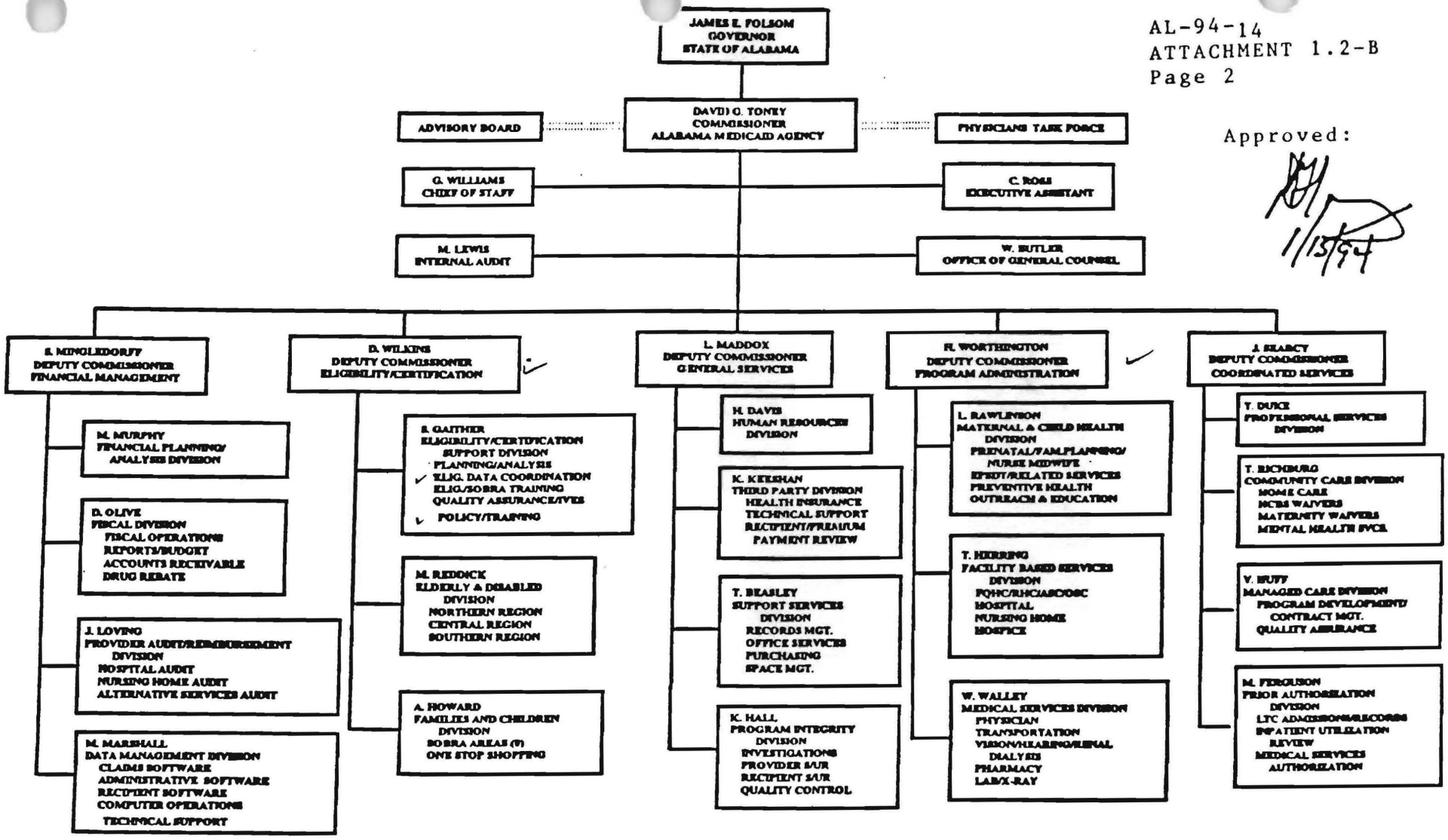
   (l) assure that claims for the medical care of Medicaid recipients are properly paid;

   (m) perform eligibility functions and,

   (n) establish criteria for admission to Long Term Care facilities to include evaluation and certification of recipients.

Approved:

1/13/94



Date/Receipt 5/20/94
Date/Approved 6/22/94
Date/Effective 4/1/94

TN No. AL-94-14
Supersedes
TN No. AL 93-28

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

Professional Medical Personnel and Supporting Staff

Alabama Medicaid Agency, the single state agency responsible for administration of the Medical Assistance Program, is headed by a Commissioner. The personnel assigned to Medicaid are classified as Skilled Professional Medical Personnel and supporting staff, or other supporting staff with related responsibility as follows:

1. Skilled Professional Medical Personnel and Support Staff (53)

   a. Physician (2)

      The physicians serve as consultants on professional medical matters to all programs within Medicaid.

   b. Dentist (1)

      The dentist serves as a consultant on all professional dental matters.

   c. Pharmacist (2)

      The pharmacists are responsible for planning, directing, and supervising the state-wide drug program and developing and maintaining a drug formulary.

   d. Medicaid Administrators (7)

      One administrator, a registered nurse, is the manager of the Hospital Program, assisted by an administrator. One administrator, a registered nurse, is the Director of Managed Care Division, assisted by two administrators, who are registered nurses. One administrator, a registered nurse is the Director of the Community Care Division. One administrator, a registered nurse, is the Director of the Prior Authorization Division.

e. Nurses (23)

(1) Four nurses are assigned to the Prenatal/ Family Planning Program, one of whom is the manager. Three of these nurses are assigned to the Family Planning Section.

(2) One nurse is assigned as the manager of the Lab/X-Ray program.

(3) Fifteen nurses are assigned to the Prior Authorization Program.

(4) Three nurses are assigned to the FQHC/Rural Health/ ASC/OSL Program, one of whom is the manager.

f. Medical Care Benefits Specialists (4)

(1) One Medical Care Benefits Specialist is assigned as a sub-professional to the Hospital Program to assist in its operation.

(2) Two Medical Care Benefits Specialists are assigned as sub-professionals to the Inpatient Utilization Review Program to assist in its operation.

(3) One Medical Care Benefits Specialist is assigned as a sub-professional to the FQHC/Rural Health/ASC/OSL.

g. Clerical (14)

These individuals are clerical personnel who directly support the Skilled Medical Personnel.

2. Other Support Staff (507)

a. Medicaid Administrators (52)

Medicaid Commissioner	1
Medical Services Administrators	4
Accounting Managers	2
Chief Investigator	1
Executive Assistant	1
Chief Auditor	1
Data Processing Information Systems Managers	2
General Counsel-Attorney III	1
Medicaid Administrators	39

Chief of Staff	1
Program Integrity Director	3
Certification Support Division	2
Family Certification Division	1
Institutional & SSA Related Certification Division	4
Support Services Division	3
Third Party Division	4
Human Resources Division	1
Financial Analysis & Planning	2
Facility Based Services Director	2
Community Care Division	6
Medical Services Division	5
Maternal & Child Health Division	3
Managed Care Division	2

b. Accountants (7)

Internal Audit	1
Fiscal Operations	2
Accounts Receivable	1
Drug Rebates	1
Reports & Budget	1
Systems Audit	1

c. Account Clerks (9)

d. Administrative Assistants (5)

e. Auditors (35)

Provider Audit	24
Fiscal	1
Program Integrity	1
Internal Audit	9

f. Budget Analyst (1)

g. Legal Counsel (4)

These individuals maintain liaison with the Attorney General and advise the Commissioner on all fair hearings and legal matters.

h. Special Investigators (6)

These individuals perform investigations relative to recipient and provider abuse, misuse and fraud.

i. Information Specialists (2)

j. State Professional Trainees (3)

k. Personnel Assistant (1)

l. Data Processing Information Systems Managers (2)

m. Computer Programmers & Analysts (25)

n. Data Processing Specialists (2)

o. Data Entry and Computer Operations (8)

p. Medical Care Benefit Specialists (48)

q. Nurses (26)

S/UR	10
Physicians/Transportation	1
EPSDT	5
Maternity Waiver	3
Preventive Services	1
HCBS Waiver Services	3
Home Care/MH	3

r. Medicaid Eligibility Specialists (97)

Quality Control	3
Third Party	3
One Stop Shopping	1
Certification Support	5
Institutional/SSA Central Office	1
District Offices	75
Outstationed	8
Family Certification Central Office	1

s. Financial Support Social Workers (103)

Certification Support	1
One Stop Shopping	1
Mental Health Services	1
Outstationed	100

t. Statisticians (3)

Financial Planning and Analysis	3

u. Other (10)

Telephone Coordinator	1
General Services Supervisor	1
Stock Clerk	1
Telephone Operators	2
Laborers	2
Utility Laborers	2
Central Mailroom Clerk	1

v. Clerical (58)

EXHIBIT B
FEDERAL FINANCIAL PARTICIPATION RATE
BY COST CENTER

Cost Center Number	Cost Center	Old Cost Center Number	Number of Personnel	Functional Personnel
A	GENERAL ADMINISTRATION			
AA05	Commissioner	AA05	3	
W	CHIEF OF STAFF			
WA05	Chief of Staff	WA05	2	
WC05	Public Relations	MA05,MB05	2	
Y	DEPUTY COMMISSIONER-PROGRAM ADMIN.			
YA05	Depty.Commissioner-Program Admin.	YA05	2	
4	DEPUTY COMMISSIONER-			
4A05	Depty.Commissioner-Elig/Certification	***	3	
X	DEPUTY COMMISSIONER-GENERAL SERVICES			
XA05	Depty.Commissioner-General Service	XA05	2	
XB05	Liens Operations	XB05	2	
2	DEPUTY COMMISSIONER-COORDINATED SERVICES			
2AS7	Depty.Commissioner-Coordinated Servs.	***	1	SPMP
Z	DEPUTY COMMISSIONER-FINANCIAL MANAGEMENT			
ZA05	Depty.Commissioner-Financial Management	***	1	
1	INTERNAL AUDIT DIVISION			
1A05	Director	***	1	
1BM7	Fiscal Agent Liaison/Systems Audit	AAM7,HL05,HLM7	9	MMIS
1C05	Rate Setting	QF05	9	
1D05	Internal Auditor	***	1	

F	FISCAL DIVISION			
FA05	Director	FA05	2	
FB05	Fiscal Operations	FB05	3	
FC05	Accounts Receivable	FC05	4	
FG05	Reports/Budget	FG05	2	
FL05	Drug Rebate	HR05	4	
G	PROVIDER AUDIT/ REIMBURSEMENT DIV.			
GA05	Director	FH05	4	
GB05	Nursing Home Audit	FJ05	7	
GD05	Hospital Audit	FI05	8	
GE05	Alternative Servs. Audit	FK05	9	
H	PROGRAM INTEGRITY DIV.			
HA05	Director	HA05	3	
HCM7	Provider SUR Unit	HCM7	9	MMIS
HE05	Quality Control	HE05	5	
HO05	Investigations	HO05	8	
HSM7	Recipient SUR	HSM7	7	MMIS
I	DATA MANAGEMENT DIV.			
IAM7	Director	IAM7	4	MMIS
IBM7	Claims Software	ABM7	8	MMIS
IB05	Claims Software	IB05	1	
ICM7	Admin. Support	ICM7	8	MMIS
IC05	Admin. Support	IC05	0	
IDM7	Recipient Software	IDM7	9	MMIS
ID05	Recipient Software	ID05	1	
IEM7	Computer Operations	IEM7	10	MMIS
IGM7	Technical Support	***	3	MMIS
J	CERTIFICATION SUPPORT DIVISION			
JA05	Director	JA05	2	
JC05	Policy & Training	JA05	5	
JM05	Technical Support	JA05	3	
JX05	Data Coordination	JA05,DE05	3	
B	FAMILY CERTIFICATION			
BAM7	Director	BAM7	3	MMIS
BC05	Mobile Outstationed Area	BC05	15	
BD05	Montgomery Center Outstationed Area	BD05	11	
BE05	Birmingham Out-stationed Area	BE05	17	
BF05	Decatur Out-stationed Area	BF05	13	
BG05	Dallas Out-stationed Area	BG05	11	

BH05	Gadsden Out-stationed Area	BH05	15	
BI05	Montgomery SOU Outstationed Area	BD05	13	
BJ05	Tuscaloosa Out-stationed Area	BJ05	13	
BZ00	One Stop Shopping	***	3	100% FFP
5	INSTITUTIONAL & SSA RELATED CERT.DIV.			
5A05	Director	***	3	
CA05	Certification Region Supervisor	CA05	1	
CB05	Birmingham District Office	CB05	10	
CBM7	Birmingham District Office	CBM7	3	MMIS
CD05	Opelika District Office	CD05	8	
CDM7	Opelika District Office	CDM7	2	MMIS
CE05	Selma District Office	EC05	6	
CEM7	Selma District Office	ECM7	2	MMIS
DA05	Certification Region Superv.	DA05	1	
DB05	Florence District Office	DB05	7	
DBM7	Florence District Office	DBM7	2	MMIS
DC05	Decatur District Office	DC05	7	
DCM7	Decatur District Office	DCM7	2	MMIS
DF05	Gadsden District Office	CC05	8	
DFM7	Gadsden District Office	CCM7	2	MMIS
DG05	Tuscaloosa District Office	EB05	8	
DGM7	Tuscaloosa District Office	EBM7	2	MMIS
EA05	Certification Region Supervisor	EA05	1	
ED05	Mobile District Office	ED05	8	
EDM7	Mobile District Office	EDM7	2	MMIS
EE05	Dothan District Office	DD05	7	

EEM7	Dothan District Office	DDM7	2	MMIS
EF05	Montgomery District Office	JQ05	6	
EFM7	Montgomery District Office	JQM7	2	MMIS
K	SUPPORT SERVICES DIV.			
KA05	Director	KA05	1	
KB05	Records Management	KB05	2	
KC05	Office Services	KC05	6	
KD05	Purchasing	FE05	3	
KE05	Admin. Procedures	KA05	4	
L	THIRD PARTY DIVISION			
LAM7	Director	LAM7	2	MMIS
LBM7	Health Insurance	LBM7	9	MMIS
LC05	Technical Support	LC05	8	
LDM7	Recipient & Premium Review	LD05	5	MMIS
N	HUMAN RESOURCES DIV.			
NA05	Director	NA05	6	
O	GENERAL COUNCIL DIV.			
OA05	Director	OA05	5	
P	FINANCIAL PLANNING & ANALYSIS DIVISION			
PA05	Director	YB05	6	
Q	FACILITY BASED SERVICES DIVISION			
QA05	Director	QA05	2	
QBS7	Hospital Program	QB05	4	SPMP
QC05	Nursing Home Prog.	QC05	3	
QDS7	FQHC Rural Health ASC OSL	QDS7	4	SPMP
R	COMMUNITY CARE DIV.			
RAS7	Director	QGS7	2	SPMP
RD05	HCBS Waivers	QH05	12	
RG05	Maternity Waiver Prog.	TB05	5	
RH05	Home Care/Mental Health Services	QGS7,UB05	7	
S	MEDICAL SERVICES DIV.			
SA05	Director	SAS7	2	
SB05	Physicians/ Transportation Prog.	SBS7	6	
SCS7	Pharmacy Program	SCS7	5	SPMP

S	MEDICAL SERVICES DIV.			
SC05	Pharmacy Program	SC05	1	
SC05	Vision/Hearing/ Renal Dialysis Prog.	SD05	2	
SCS7	Lab/X-ray Program	SGS7	2	SPMP
T	MATERNAL & CHILD HEALTH DIVISION			
TA05	Director	TA05	2	
TC05	EPSDT/Related Serv.	TC05	8	
TD05	Preventive Health	TD05	3	
TE05	Outreach & Education	MC05	3	
TOS7	Prenatal/Nurse Midwife Program	TOS7	2	SPMP
TOF9	Family Planning	TOF9	3	SPMP
U	MANAGED CARE DIVISION			
UAS7	Director	UA05	3	SPMP
UC05	Program Development & Contracts	UC05	5	
UES7	Quality Assurance	UE05	1	SPMP
V	PROFESSIONAL SERVICES DIV.			
VAS7	Director	VAS7	4	SPMP
3	PRIOR AUTHORIZATION DIV.			
3AS7	Director	VBS7	2	SPMP
3BS7	Medical Services Authorization	VBS7	5	SPMP
3CS7	Inpatient Utilization Review	VCS7	9	SPMP
3DS7	LTC Administration/ Records	QCS7	6	SPMP
3DM7	LTC Records	QCM7	4	MMIS
			560	

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

Eligibility Determination Staff and Functions

There are four agencies in Alabama that certify individuals for Medicaid. These agencies certify certain groups of individuals for Medicaid based on their circumstances.
These agencies are:
The Social Security Administration (SSA),
The Alabama Department of Public Health (ADPH),
The Department of Human Resources (DHR), and
The Alabama Medicaid Agency (AMA).

The Social Security Administration certifies individuals for the following programs: Alabama is a Section 1634 state and accepts Social Security Administration's eligibility determination for aged, blind, or disabled persons who have low income that may qualify for cash assistance through the Supplemental Security Income (SSI) program. Individuals eligible for Supplemental Security Income (SSI) are automatically eligible for Medicaid.

The Department of Human Resources certifies individuals for the following programs: Foster children and children who receive State or Federal Adoption Assistance, poverty level pregnant women, children under age 19, section 1931 Medicaid for Low Income Families Program (MLIF), and Plan First Waiver.

The Alabama Department of Public Health certifies individuals for the following programs: Nursing Home Program, Hospital Program, Post Hospital Extended Care (PEC) Program, Institutional Care Facility for the Mentally Retarded (ICF-MR) Program, Home and Community Based Waiver for Person with Intellectual Disabilities (ID), Elderly and Disabled Waiver, State of Alabama Independent Living (SAIL) Waiver, HIV/AIDS Waiver, OBRA Waiver, Living at Home (LAH) Waiver, Technology Assisted Waiver for Adults, Alabama Community Transition (ACT) Waiver, Newborn Program, Program of All-Inclusive Care for the Elderly (PACE), poverty level pregnant women, children under age 19, section 1931 Medicaid for Low Income Families Program (MLIF), Plan First Waiver **SSI related groups:** Widow/Widower, Disabled Adult Child, Retroactive SSI, Children of SSI Mothers, Continuous (PICKLE), Grandfathered Children. **Medicare related groups**: Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Income Individuals and Qualified Disabled Working Individuals.

The Alabama Medicaid Agency certifies individuals for the following programs: Poverty level pregnant women, children under age 19, Plan First Waiver, Breast and Cervical Cancer Program (BCC), Nursing Home Program, Hospital Program, Post Hospital Extended Care (PEC) Program, Institutional Care Facility for the Mentally Retarded (ICF-MR) Program, Home and Community Based Waiver for Person with Intellectual Disabilities (ID), Elderly and Disabled Waiver, State of Alabama Independent Living (SAIL) Waiver, HIV/AIDS Waiver, OBRA Waiver, Living at Home (LAH) Waiver, Technology Assisted Waiver for Adults, Alabama Community Transition (ACT) Waiver, Newborn Program, Program of All-Inclusive Care for the Elderly (PACE), **SSI related groups:** Widow/Widower, Disabled Adult Child, Retroactive SSI, Children of SSI Mothers, Continuous (PICKLE), Grandfathered Children. **Medicare related groups**: Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Income Individuals and Qualified Disabled Working Individuals, **Others:** Emergency Services for Aliens, Department of Youth Services (DYS) Children; Refugees and section 1931 MLIF; and Child Health Insurance Program (CHIP).

1. Eligibility Staff and Functions

   a. Financial Support Worker I and II (DHR)

      This is a DHR position which determines eligibility for foster children and children who receive State or Federal Adoption Assistance, MAGI related groups, section 1931 MLIF and Emergency Services.

   b. Medicaid Eligibility Specialist (AMA)

      This is an AMA position which determines eligibility for MAGI related groups, section 1931 MLIF, Emergency Services, Plan First Waiver, Refugees, and Medicare related groups.

   c. Medicaid Eligibility Specialist, Senior (AMA)

      This is an AMA position which determines eligibility for all Aged, Blind, and Disabled coverage groups not administered through the Social Security Administration.

   d. Public Health Social Worker I and II (ADPH)

      This is an ADPH position which determines eligibility for MAGI related groups, section 1931 MLIF, Emergency Services, Plan First Waiver, Refugees, and Medicare related groups.

   e. Public Health Social Worker III (ADPH)

      This is an ADPH position which determines eligibility for all Aged, Blind, and Disabled coverage groups not administered through the Social Security Administration.

2. Supervisory and Administrative Staff

   a. Administrative Assistant I, II and III (AMA, ADPH, and DHR)

      Duties for these positions include filing, sorting mail, typing documents, proofreading documents, making copies, greeting and directing the public, taking telephone messages, posting/logging transmittal records or making simple calculations. These positions process annual eligibility redeterminations for MAGI related groups, section 1931 MLIF, Emergency Services, Plan First Waiver, Refugees, and Medicare related groups.

b. Medical Care Benefits Specialist I and II (AMA)

Duties for these positions include performing administrative functions such as time and attendance reports, travel requests, activity reports, scheduling/planning meetings, and distribution of mail throughout the division. These positions process annual eligibility redeterminations for MAGI related groups, section 1931 MLIF, Emergency Services, Plan First Waiver, Refugees, and Medicare related groups.

c. Health Insurance Assistant (AMA and ADPH)

This position determines eligibility for MAGI related groups, section 1931 MLIF, Emergency Services, Plan First Waiver, Refugees, and Medicare related groups.

d. Health Insurance Specialist (AMA and ADPH)

This position determines eligibility for MAGI related groups, section 1931 MLIF, Emergency Services, Plan First Waiver, Refugees, and Medicare related groups.

e. Medicaid Eligibility Specialist Supervisor (AMA)

This position provides supervision to previous classifications and performs eligibility determination oversight.

f. Medicaid Eligibility Manager (AMA)

This position provides supervision to previous classifications and performs eligibility determination oversight.

g. Medicaid Administrator II and III (AMA)

This position provides supervision to previous classifications and performs eligibility determination oversight.

h. Program Supervisor (DHR)

This position provides supervision to previous DHR classifications and performs eligibility determination oversight.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

Definition of a Health Maintenance Organization

Within the guidelines of 42 CFR §434.20(c) and Alabama Department of Public Health Administration Code Rule 420-5-6.01 - 420-5-6.15 the definition of a Health Maintenance Organization, herein abbreviated as HMO, means a licensed entity which provides, either directly, or through arrangements, those health care services, medical assistance, and rehabilitation services which enrollees might reasonably require in order to be maintained in good health.

Such HMO services shall be provided to each enrollee on a capitation fee basis. Such HMO services shall include, but not be limited to, the following, wherever provided:

1. Medical assessment and evaluation
2. Physician services; which shall include consultant and physician referral services
3. Inpatient and outpatient hospital services
4. Medically necessary emergency health services
5. Diagnostic laboratory and diagnostic and therapeutic radiologic services
6. Home Health services
7. Preventive health services; which shall include periodic health evaluations for adults, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and immunizations and may include voluntary family planning

In addition an HMO must meet at least the following requirements:

(1) The HMO makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid recipients within its service area.

(2) The HMO makes provision, satisfactory to the Medicaid Agency, against the risk of insolvency, and assures that Medicaid enrollees will not be liable for its debts if it does become insolvent, and;

(3) Be organized primarily for the purpose of providing health care services.

State: Alabama

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	2.	Deemed Recipients of AFDC.
DHR AMA ADPH	b.	Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
Sec. 1902(a)(10)(A)(i)(I)of the Act 42 USC § 1396a		
DHR AMA ADPH Sec. 402(a)(22)(A) of the Act 42 USC § 602	c.	Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
DHR AMA ADPH 406(h), Sec. 1931, Sec. 1902(a)(10)(A)(i)(I), and Sec. 1925 of the Act 42 USC § 1396a 42 USC § 1396r-6 42 USC § 1396u-1 42 CFR 435.112	d.	An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
DHR AMA ADPH Sec. 1902(a) of the Act 42 USC § 1396a	e.	Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

State: Alabama

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
DHR AMA ADPH	3.	Qualified Family Members (Medicaid Only)
Sec. 407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act 42 USC § 1396a 42 USC § 1396d		See Item A.10, pg 4a.
DHR AMA ADPH	4.	Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)
Sec. 1902(a)(52) and 1925 of the Act 42 USC § 1396a 42 USC § 1396 r-6		

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
DHR AMA ADPH Sec. 1902(a)(10) (A)(i)(V) and 1905 of the Act 42 USC § 1396a	10. Individuals other than qualified women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.
DHR AMA ADPH Sec. 1902(e)(5) of the Act 42 USC § 1396a	a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
DHR AMA ADPH Sec. 1902(e)(6) of the Act 42 USC § 1396a	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy of the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
DHR AMA ADPH Sec. 1902(e)(4) of the Act 42 USC § 1396a	12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
SSA 42 CFR § 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance ☒ a. Individuals receiving SSI. This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act. X Aged X Blind X Disabled

State: Alabama

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

435.121

13. /_/ b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medi caid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

1619(b)(1) of the Act

___ Aged
___ Blind
___ Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

State: Alabama

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

SSA 1902(a)(10)(A)(i)(II) and 1905(q) of the Act

14. Qualified severely impaired blind and disabled individuals who--

a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

State: Alabama

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

SSA

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

/_/ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

State: Alabama

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1619(b)(3) of the Act

/ The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
AMA ADPH	Sec. 1634(c) of the Act 42 USC § 1383c 42 CFR 435, Subpart B	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who-- a. Are at least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility. ☐ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of count able income for categorically needy eligibility. ☐ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
AMA ADPH	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

*Agency that determines eligibility for coverage.

State: Alabama

Agency*	Citation(s)	Groups Covered
DHR	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

State: Alabama

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

/__/ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

___Aged ____ Blind ___ Disabled

/X/ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
AMA ADPH 42 CFR 435.132	19.	Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
AMA ADPH 42 CFR 435.133	20.	Blind and disabled individuals who-- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
AMA ADPH 42 CFR 435.134	21.	Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.
		☐ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).
		☒ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or a nursing facility (this group was included in this State's August 1972 plan).
		☐ Not applicable with respect to nursing facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

AMA ADPH
42 CFR 435.135

22. Individuals who--

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

☐ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
AMA ADPH 1634 of the Act 42 USC § 1383c 42 CFR 435.137	23.	Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act. ☐ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients. ☐ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
AMA ADPH	24.	Disabled widows and widowers who would be eligible for SSI except for receipt of early social security disability benefits, who are not entitled to hospital insurance under Medicare Part A and who are deemed, for purposes of title XIX, to be SSI beneficiaries under section 1634(d) of the Act.
1634(d) of the Act 42 USC § 1383c 42 CFR 435.138		☐ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients. ☐ Not applicable because the State applies more restrictive eligibility than those under SSI and the State chooses not to deduct any of the benefit that caused SSI/SSP ineligibility or subsequent cost-of-living increases. ☐ The State applies more restrictive eligibility requirements than those under SSI and part or all of the amount of the benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)		Groups Covered
AMA ADPH	OBRA 90, Sec. 5103, Sec. 1634 (d)(2) of the Act 42 USC § 1383c	24a.	Disabled widows and widowers and disabled surviving divorced spouses who would be eligible for SSI except for entitlement to an OASDI benefit resulting from a change in the definition of disability, effective 1/1/91, and who are deemed, for the purposes of title XIX, to be SSI recipients under 1634 of the Act.

*Agency that determines eligibility for coverage.

State: Alabama

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
AMA ADPH	25.	Qualified Medicare Beneficiaries –
Sec. 1902(a)(10)(E)(i), Sec. 1905(p) and Sec. 1860D-14(a)(3)(D) of the Act 42 USC § 1383a 42 USC § 1396d 42 USC § 1395w-114		a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
AMA ADPH	26.	Qualified Disabled and Working Individuals --
Sec. 1902(a)(10)(E)(ii), Sec. 1905(p)(3)(A)(i), Sec. 1905(p) and 1860D-14(a)(3)(D) of the Act 42 USC § 1396a 42 USC § 1396d 42 USC § 1395w-114		a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed two times the SSI resource limit. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

*Agency that determines eligibility for coverage

State: Alabama

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
AMA ADPH	Sec. 1902(a)(10)(E)(iii), Sec. 1905(p)(3)(A)(ii), and Sec. 1860D-14(a)(3)(D) of the Act 42 USC § 1396a 42 USC § 1396d 42 USC § 1395w-114	27. Specified Low-Income Medicare Beneficiaries -- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)
AMA ADPH	Sec. 1902(a)(10)(E)(iv) and Sec. 1905(p)(3)(A)(ii) and Sec. 1860D-14(a)(3)(D) of the Act 42 USC § 1396a 42 USC § 1396d 42 USC § 1395w-114	28. Qualifying Individuals -- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level; c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

* Agency that determines eligibility for coverage.

State: Alabama

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
AMA ADPH	Sec. 1634 (e) 42 USC § 1383c	29. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of Section 1611 (e) (3) (A) shall be treated, for purposes of Title XIX, as receiving benefits for the month.

* Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy

42 CFR 435.210
Sec. 1902(a)(10)(10)(A)(ii) and the Act
42 USC § 1396a

1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42CFR 435.230, but who do not receive cash assistance.

☐ The plan covers all individuals as described above.

☐ The plan covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Caretaker relatives
___ Pregnant women
___ Individuals under the age of

___ 18
___ 19
___ 20
___ 21

AMA ADPH
42 CFR 435.211

☒ 2. Individuals who would be eligible for AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

DHR AMA ADPH
42 CFR 435.212 & Sec. 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508 (section 4732)
42 USC § 1396a
42 USC § 1396n
42 CFR 435.211

__3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or a managed care organization (MCO), or primary care case management (PCCM) program but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in Section 1905(a)(4)(C).

____ The State elects not to guarantee eligibility.

__X__ The State elects not to guarantee eligibility. The minimum enrollment period is Six months (not to exceed six).

The State measures the minimum enrollment period from:

_____ The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

__X__ The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

_____ The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment of periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
DHR AMA ADPH	Sec. 1932(a)(4) of the Act 42 USC § 1396u-2	B. Optional Groups Other Than Medically Needy The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible. ___ Disenrollment rights are restricted for a period of _____ months (not to exceed 12 months). During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment. _X_ No restrictions upon disenrollment rights. In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract. ___ The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost. ___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.
	Sec. 1903(m)(2)(H), Sec. 1902(a)(52) of the Act P.L. 101-508 42 CFR 438.56(g) 42 USC § 1396a 42 USC § 1396b	

Agency*	Citation(s)		Groups Covered
	B.		Optional Groups Other Than the Medically Needy (Continued)
	☐		The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).
AMA ADPH 42 CFR Part 441 42 USC 1396n	☒	4.	A group or groups of individuals who would be eligible for Medicaid 435.217 under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
AMA ADPH 42 CFR Part 460	☒	5.	PACE enrollees.

*Agency that determines eligibility for coverage.

State: Alabama

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(VII) of the Act

/ / 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

/ / The State covers all individuals as described above.

/ / The State covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
  ___ 21
  ___ 20
  ___ 19
  ___ 18
___ Caretaker relatives
___ Pregnant women

*Agency that determines eligibility for coverage.

State: _____

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

DHR 42 CFR 435.230 X 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

___(1) All aged individuals.

___(2) All blind individuals.

___(3) All disabled individuals.

State: Alabama

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

___(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

DHR 42 CFR 435.230

___(5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___(7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

_X_(8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___(9) Individuals in additional classifications approved by the Secretary as follows:

State: Alabama

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes.

_X_ No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

State: Albama

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230 / / 11. Section 1902(f) States and SSI criteria
435.121 States without agreements under section 1616 or 1634 of the Act.

1902(a)(10)(A)(ii)(XI) of the Act

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

State: Alabama

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (6) Disabled individuals in domicili ary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (9) Individuals in additional classifications approved by the Secretary as follows:

State: Alabama

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes

___ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

AMA ADPH
42 CFR 435.236
Sec. 1902(a)(10)
(A)(ii)(V)
of the Act
42 USC 1396a

☒ 12. Individuals who are in institutions for least 30 consecutive days and who are eligible under a special income level Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1, page 9a. to ATTACHMENT 2.6-A.

☐ The State covers all individuals as described above.

☒ The State covers only the following group or groups of individuals:

AMA ADPH
Sec. 1902(a)(10)(A)
(ii) and 1905(a)
of the Act
42 USC 1396a

X Aged
X Blind
X Disabled
__ Individuals under the age of--
__ 21
__ 20
__ 19
__ 18
__ Caretaker relatives
__ Pregnant women

State: Alabama

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(e)(3) of the Act

/ / 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act

/ / 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and

b. Infants under one year of age.

State: Alabama

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(ii)(X) and 1902(m)(1) and (3) of the Act /_/ 16. Individuals--

a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

c. Whose resources do not exceed the maximum amount allowed under SSI; or under the State's medically needy program as specified in ATTACHMENT 2.6-A. Supplement 2, pg. 6.

State/Territory: Alabama

Citation	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plans remain for a minimum enrollment period of _____ months.
1902(a) (100 (F) 1902(u) (1) of the act	19. Individuals entitled to elect COBRA and continuation coverage and whose income as determined under section 1612 of the act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

Citation(s)	Groups Covered
	EXPLANATION OF THE METHODOLOGIES USED TO ESTABLISH COUNTABLE INCOME AND RESOURCES
DHR AMA ADPH Sec. 1902 (E) of the Act X 20. 42 USC 1396a	A child under age 19 (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.
Sec. 1920A of the Act __21. 42 USC 1396r-1	Children under age 19 who are determined by a "qualified entity" (as defined in 1920A(b)(3)(A) based preliminary information, to meet the highest applicable income criteria specified in this plan as applicable to children. The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

State: Alabama

Citation			Group Covered
		B. Optional Coverage Other Than the Medically Needy (Continued)	
1902 (a) (10) (A) (ii) (XVIII) of the Act	X	24.	Women who: a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of Section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix; b. are not otherwise covered under creditable coverage, as defined in Section 2701 (c) of the Public Health Service Act; c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; d. must meet Medicaid citizenship and alienage status; and e. have not attained age 65.
1920B of the Act	__	25.	Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) bay the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

State: Alabama

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.301 This plan includes the medically needy.

_X_/ No.

/_/ Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)(C)(ii)(I) of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

State: _____

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

1902(e)(4) of the Act

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible or would remain eligible if she were pregnant and the child is a member of the woman's household.

42 CFR 435.308

5. /_/ a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--
___21
___20
___19
___18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

/_/ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

___ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

___ (a) In foster homes (and are under the age of _____).

___ (b) In private institutions (and are under the age of _____).

State: Alabama

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

___ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___).

___ (2) Individuals in adoptions subsi dized in full or part by a public agency (who are under the age of _____).

___ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ____).

___ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

___ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State: Alabama

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

42 CFR 435.310 /_/ 6. Caretaker relatives.

42 CFR 435.320 and 435.330 /_/ 7. Aged individuals.

42 CFR 435.322 and 435.330 /_/ 8. Blind individuals.

42 CFR 435.324 and 435.330 /_/ 9. Disabled individuals.

42 CFR 435.326 /_/ 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.

435.340 11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;

b. Were eligible as medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

State: Alabama

Citation(s)	Groups Covered
	C. Optional Coverage of Medically Needy (Continued)
1906 of the Act	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation(s)	Groups Covered
AMA ADPH	Sec. 1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904 42 USC 1396a 42 USC 1396u-5	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

State: Alabama

Citation		Condition or Requirement
	b.	For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c.	For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d.	For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.407/6	3.	Is residing in the United States and--
	a.	Is a citizen;
ec. 245A of the Immigration and Nationality Act	b.	Is an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, as defined in 42 CFR 435.408;
1902(a) and 1903(v) of the Act and 245(h)(3)(B) of the Immigration & Nationality Act	c.	Is an alien granted lawful temporary resident status under section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of P.L. 96-422.

P&I Change 7/12/02

State: Alabama

Citation	Condition or Requirement

d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or

e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).

42 CFR 435.403
1902(b) of the Act

4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.

/X/ State has interstate residency agreement with the following States:

California	Kentucky	New Jersey	Texas
Florida	Louisiana	New Mexico	Iowa
Georgia	Ohio	Wisconsin	Minnesota
Mississippi	Pennsylvania	Tennesse	

/ / State has open agreement(s).

/ / Not applicable; no residency requirement.

State/Territory: Alabama

Citation			Condition or Requirement
42 CFR435.1008	5.	a.	Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act		b.	Is not a patient under age 65 in an institution for mental diseases except as inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program.
			/_/ Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42CFR 433.145 1912 of the Act	6.		Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order)

State/Territory: Alabama

Citation	Condition or Requirement
	An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(1)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State Plan and providing information to assist in pursuing these third parties. Any individuals may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.
	/X/ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

State: Alabama

Citation	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, is such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

State: Alabama

Citation	Condition or Requirement
	B. Posteligibility Treatment of Institutionalized Individuals' Incomes:
	1. The following items are not considered in the posteligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under Sections 1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v. Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under Sections 500-506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparation Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P.L. 100-383	d. Japanese and Aleutian Restitution Payments.
1.(a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement of the Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P.L. 103-66	h. VA pensions limited to $90.00 per month under 38 U.S.C. 5503.

State: Alabama

Citation		Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2.	The following amounts for personal needs are deducted from total income in the application of an individual's or couple's income to the cost of institutional care: Personal Needs Allowance (PNA) of not less than $30 for Individuals and $60 for couples for all institutional persons. a. Aged, blind, disabled -- Individuals $30.00 Couples $Not Applicable For the following persons with greater need: Supplement 14 to Attachment 2.6-A describes the greater need; describes the basis or formula for amount if not listed above; lists the criteria to be met; and where appropriate, identifies the authority for approving that a criterion is met. b. AFDC related: Children $_____ Adults $_____ For the following persons with a greater need: Supplement 14 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate, identifies the authority for approving that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B.7 of Attachment 2.2-A $_____ For the following persons with a greater need: Supplement 14 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the

Diane will pencil in c. next time plan change submit this.

State: Alabama

Citation		Condition or Requirement
		deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate, identifies the authority for approving that a criterion is met.
1924 of the Act	3.	In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:
		a. The monthly income allowance for the community spouse, calculated using the formula in Section 1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in Section 1924(d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.
		_x_ The poverty level component is calculated using the applicable percentage (set out in Section 1924(d)(3)(B) of the Act) of the official poverty level.
		___ The poverty level component is calculated by using a percentage greater than the applicable percentage, equal to ____%, of the official poverty level (still subject to maximum maintenance needs standard).
		___ The maintenance needs standard for all community spouses is set at the maximum permitted by 1924 (d)(3)(C).

Citation	Condition or Requirement

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or the amount of any court ordered support.

In determining excess shelter allowance, utility expenses are calculated using:

___ the standard utility allowance under Section 5(e) of the Food Stamp Act of 1977; or

_x_ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

_x_ one-third of the amount by which the poverty level component (calculated under Section 1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in Section 1924 (d)(3)(B) exceeds the dependent family member's monthly income.

___ a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under Section 1924(d)(1):

The IRS definition of dependency for tax reporting purposes is used to define dependent children, parents, and siblings for purposes of deducting allowances under Section 1924.

State: Alabama

Citation	Condition or Requirement

c. Amounts for health care expenses described below

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State Plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

435.725
435.733
435.832

4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple.

a. An amount for the maintenance needs of each member of a fmily living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:

( ) AFDC level; or
( ) Medically needy level:

(Check one)

_x_ AFDC levels in Supplement 1
__ Medically needy level in Supplement 1
__ Other: $_____

b. Amounts for health care expenses described below that have not been deducted under 3.c above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:

Citation	Condition or Requirement
	For individuals with greater need-[3]
	(ii) AFDC related--* Children $_____[4] Adults $_____
	*For AFDC related individuals in the first partial month of institutionalization, the individual is considered to remain in the AFDC group and there is no patient liability for the initial partial month. In the second month (the first full month) of institutionalization, the individual is considered to be SSI-related and is given the same PNA as in Item B.2.a. above. For individuals returning to an AFDC group from the institution, for the last partial month of institutionalization, the individual is treated as an SSI-related individual for the entire month and is given the same PNA as in Item B.2.a. above. The individual is considered to return to the AFDC group in the second month (first full month) after being released from the institution.

[3] Supplement 14 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be meet; and where appropriate, identifies the authority for approving that a criterion is met.

[4] For individuals receiving a VA pension limited to up to $90 a month under Section 601 of P.L. 102-568, the Personal Needs Allowance is the greater of the amount permitted to be paid under Section 601 (up to $90) and the amount specified in this section.

Citation	Condition or Requirement
	For individuals with greater need-[5]
	(iii) Individuals under age 21 covered in this plan as specified in Item B.7. of ATTACHMENT 2.2-A. $_____
	For individuals with greater need-[6]
435.725 435.733 435.832	b. For the maintenance of each member of non-institutionalized family at home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the: ° AFDC level; or ° Medically Needy level; -AFDC level $_____ *Refer to Supplement 1 to ATTACHMENT 2.6-A, Page 1.1 -Medically Needy level $_____ -Other $_____

[5] Supplement 14 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be meet; and where appropriate, identifies the authority for approving that a criterion is met.

[6] Supplement 14 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate, identifies the authority for approving that a criterion is met.

Citation	Condition or Requirement

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State Plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

435.725
435.733
435.832

5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual, or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

x No.

__ Yes (the applicable amount is shown below.)

__ Amount for maintenance of home is:
$_____.

__ Amount for maintenance of home is the actual maintenance costs not to exceed $_____.

__ Amount for maintenance of home is deductible when countable income is determined under Section 1924(d)(1) of the Act only if the individual's home and the community spouse's home are different.

x Amount for maintenance of home is not deductible when countable income is determined under Section 1924(d)(1) of the Act.

Citation	Condition or Requirement

6. For children, each family member where there is no community spouse.

   AFDC Level $_____
   (See Supplement 1 to Attachment 2.6-A, pages 1.1 and 1.2)

   Medically needy level $_____

   Others as follows $_____

7. Amounts for incurred medical expenses not subject to payment by a third party.

   a. Health insurance premiums, deductibles and co-insurance charges.

   b. Necessary medical or remedial care not covered under the Medicaid plan(Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

8. An amount for maintenance of a single individual's home for not longer than 6 months, if a physician has certified he or she is likely to return home within that period.

   __ Yes. Amount of maintenance of home
   $_____

   _x_ No.

1902(1) of the Act

9. SSI benefits paid under Sections 1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital or nursing facility.

STATE ALABAMA

Citation | Condition or Requirement

_____ 2. A fixed standard greater than the amount which would be used if the formula described in Section 1924(d)(1)(C) were used. The standard used is $_____.

_____ c. The standards described above are used for individuals receiving home and community based waiver services in lieu of services provided in a medical and remedial care institution.

d. Definition of Dependency

The IRS definition of dependency for tax reporting purposes is used to define dependent children, parents and siblings for purposes of deducting allowances under Section 1924.

1902(1) of the Act, P.L. 99-643 (Section 3(b))
435.711
435.721
435.831

C. Financial Eligibility - Categorically and Medically Needy, Qualified Medicare Beneficiaries and Qualified Disabled Working Individuals

Except as provided under Section 1924 of the Act the policies reflected in C. items 1-5 apply. See Supplement 13 for additional policies relative to Section 1924.

1. Income disregards - Categorically and Medically Needy, Qualified Medicare Beneficiaries and Qualified Disabled Working Individuals.

State: Alabama

Citation	Condition or Requirement
42 CFR 435.711 435.721,435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply. Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII) and 1902(a)(10)(A)(ii)(IX) of the Act and aged and groups of qualified Medicare beneficiaries and Qualified Disabled Working Individuals covered under section 1902(a)(10)(E)(i) and 1902(a)(10)(E)(ii) of the Act.

State: Alabama

Citation	Condition or Requirement
____	Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
____	Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
____	Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
____	Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
X	Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
X	Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
____	Supplement 14 to ATTACHMENT 2.6-A specifies the income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under section 1902(z)(1) of the Act.

State: Alabama

Citation	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children). (1) In determining countable income for AFDC-related individuals, the following methods are used: _____(a) The methods under the State's approved AFDC plan only; or ____(b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to Attachment 2.6A
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6)	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) and 1902(e) of the Act as eligible, without regard to any changes in income of the family of which she is a member for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with income up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used. ____ The methods of the SSI program only. __X__ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State: Alabama

Citation Condition or Requirement

☑ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

☑ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

☑ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

☑ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--(SSA administered OSS)

___ SSI methods only.

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

State: Alabama

Citation	Condition or Requirement
42 CFR 435.721 and c. 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	Blind individuals. In determining countable income for blind individuals, the following methods are used:
	___ The methods of the SSI program only.
	_X_ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	___ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	___ For institutional couples, the methods specified under section 1611(e)(5) of the Act.
	___ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
	___ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
	___ SSI methods only.
	___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
	___ Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

State: Alabama

Citation	Condition or Requirement
	In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used: ___ The methods of the SSI program. _X_ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___For institutional couples: the methods specified under section 1611(e)(5) of the Act. ___ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ___ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State: Alabama

Citation	Condition or Requirement

___ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--

___ SSI methods only.

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

___ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation		Condition or Requirement
		(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) of the Act		(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f.	Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: ___ The methods of the SSI program only. _X_ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

State: Alabama

Citation	Condition or Requirement
	If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
	For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g. (1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working indivduals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act	(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iiii) of the Act, the same method as in f. is used.

State: Alabama

Citation	Condition or Requirement
1902(u) of the Act	h. COBRA Continuation Beneficiaries In determining countable income for COBRA continuation beneficiaries, the following disregards are applied: ____ The disregards of the SSI program; ____ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

State: Alabama

Citation	Condition or Requirement
1902(k) of the Act	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. / / The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship.
1902(a)(10) of the Act	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

State: Alabama

Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only
	a. Medically Needy
	(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of ____ month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.
	(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:
	(a) Health insurance premiums, deductibles and coinsurance charges.
	(b) Expenses for necessary medical and remedial care not included in the plan.
	(c) Expenses for necessary medical and remedial care included in the plan.
	___ Reasonable limits on amounts of expenses expenses deducted from income under a.(2)(a) and (b) above are listed below.
1902(a)(17) of the Act	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State: Alabama

Citation	Condition or Requirement
	a. Medically Needy (Continued)
1903(f)(2) of the Act	____ (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

Citation	Condition or Requirement
42 CFR 435.732	b. Categorically Needy - Section 1902 (f) States The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State: Alabama

Citation	Condition or Requirement
	4.b. Categorically Needy - Section 1902(f) States Continued
1903(f)(2) of the Act	____(6) Spenddown payments made to the State by the individual.
	NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

State: Alabama

Citation	Condition or Requirement
	5. Methods for Determining Resources
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act	b. Aged individuals. For aged individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:
	___ The methods of the SSI program.
	X SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
	___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

State: Alabama

Citation	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: ___ The methods of the SSI program. _X_ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Alabama

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the SSI program. _X_ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	e. Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act. The agency uses the following methods in the treatment of resources. ___ The methods of the SSI program only. ___ The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

State: Alabama

Citation	Condition or Requirement
1905(p)(1)(C) and (D) and 1902(r)(2) of the Act	5. h. For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act Agency uses the following methods for treatment of resources:. ___ The methods of the SSI program only. _X_ The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: ____ The methods of the SSI program only. ____ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act-- The agency uses the same method as in 5.h. of Attachment 2.6-A.

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

___ Same as SSI resource standards.

___ More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

State: Alabama

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: ___ Same as SSI resource standards. ___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

State: Alabama

Citation	Condition or Requirement
1902(a)(10)(C)(i) of the Act	7. Resource Standard - Medically Needy a. Resource standards are based on family size. b. A single standard is employed in determining resource eligibility for all groups. ___ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for-- ___ Aged ___ Blind ___ Disabled Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.
1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B) and 1860D-14(a)(3)(D) of the Act	8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.
1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act	9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.

State: Alabama

Citation	Condition or Requirement
1902(u) of the Act	9.1 For COBRA continuation beneficiaries, the resource standard is: ____ Twice the SSI resource standard for an individual. ____ More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

State: Alabama

Citation	Condition or Requirement
1902(u) of the Act	10. Excess Resources a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries. Any excess resources make the individual ineligible. b. Categorically Needy Only X This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources. c. Medically Needy Any excess resources make the individual ineligible.

State: Alabama

Citation	Condition or Requirement

42 CFR 435.914

11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

X Aged, blind, disabled.
X AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

___ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

___ Aged, blind, disabled.
___ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

X Aged, blind, disabled.
X AFDC-related.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

Citation	Condition or Requirement

1920(b)(1) of the Act

___(3) For a presumptive eligibility period for pregnant women only.

Coverage is available for ambulatory prenatal care for the period that begins on the date a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.

1902(e)(8) and 1905(a) of the Act

_X_ b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act, coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for--

_X_ 12 months

___ 6 months

_____ months (no less than 6 months and no more than 12 months)

Citation	Condition or Requirement

Section 1902(a)(18) and 1902(f) of the Act

12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals.

The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.

Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.

1917(c)

13. Transfer of Assets - All eligibility groups

The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.

Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.

1917(d)

14. Treatment of Trusts - All eligibility groups

The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.

___ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;

_X_ The agency meets the requirements in section 1917(d)(f)(B) of the act for use of Miller trusts.

The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
1924 of the Act	15. The Agency complies with the provisions of Section 1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: __ the maximum standard permitted by law. __ the minimum standard permitted by law; or $25,000.00 a standard that is an amount between the minimum and the maximum.

Family Needs Allowance

Spouse Only

The current Federal Benefit Rate will be used as the needs allowance for the spouse at home. Any income of the spouse at home will be deducted from the standard to determine allocation. If the spouse at home has no income, the standard will be allocated. If the income of the institutionalized spouse is below the standard, the entire income will be allocated except for the protected personal needs allowance and the veterans aid and attendance allowance.

Other Family Members

When there are other family members, the AFDC standard will be used. The total number of family members at home will be computed against this table. This standard will be used when there are other family members even though in some instances the needs allowance will be less than that of a spouse only. Any income of the family at home will be deducted from the standard to determine allocation. If the family at home has no income, the standard will be allocated. If the income of the institutionalized spouse is below the standard, the entire income will be allocated except for the protected personal needs allowance and the veterans aid and attendance. The AFDC definition of family units will be used in determining who is a family member.

	Number of Family Member When No Spouse Only	Family Needs Allowance
	1	59
EFF. Date	2	88
July 1, 1983	3	118
	4	147
	5	177
	6	206
	7	236
	8	265
	9	295
	10	324
	11	354
	12	383
	13	413
	14	442
	15	472

Rec'd _____ 85-9 _____ Dated _____

Approved 5/24/85 Eff 4/1/85

Obsolete

STATE-ADMINISTERED OPTIONAL STATE SUPPLEMENT: PAYMENT GROUPS:
INCOME LEVELS: ADDITIONAL DISREGARDS: ADDITIONAL ELIGIBILITY CRITERIA:

MEDICAL INSTITUTIONS SKILLED NURSING
FACILITIES AND INTERMEDIATE CARE FACILITIES
STATE: ALABAMA

MORE PAYMENT CATEGORIES					ADDITIONAL DISREGARD	RESTRICTIVE ELIGIBILITY CRITERIA
1	2	3	4	5	6	7
	INDIVIDUAL		COUPLE			
	Gross	Net	Gross	Net		
SKILLED NURSING FACILITY MENTAL HOSPITAL TUBERCULOSIS	300% of SSI FBR	300% of SSI FBR	300% of SSI FBR x 2	300% of SSI FBR x 2	None	
INTERMEDIATE CARE FACILITY & INTER-MEDIATE CARE FACILITY FOR THE MENTALLY RETARDED	300% of SSI FBR	300% of SSI FBR	300% of SSI FBR x 2	300% of SSI FBR x 2	None	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

D. INCOME ELIGIBILITY LEVEL - MANDATORY GROUP OF QUALIFIED DISABLED WORKING INDIVIDUALS

The income of Qualified Disabled Working Individuals will not exceed 200 percent of the Federal Poverty Level.

The poverty levels by family size are published in the Federal Register annually and will be made effective upon publication.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(1) of the Act are as follows: (as per P.M.93-5 5/93

Based on _____ percent of the official Federal income poverty line.

Family Size	Income Level
1	$_____
2	$_____
3	$_____
4	$_____
5	$_____

In an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with the title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989 /X/ 85 percent / / ____ percent (no more than 100)

Eff. Jan. 1, 1990: /X / 100 percent / / _____ percent (no more than 100)

Eff. Jan. 1, 1991: 100 percent

Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size	Income Levels
_____	$_____
_____	$_____

For this group, the income eligibility level is 100 percent of the Federal Poverty Level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1989 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: /__/ 80 percent /__/ _____ percent (no more than 100)

Eff. Jan. 1, 1990: /__/ 85 percent /__/ _____ percent (no more than 100)

Eff. Jan. 1, 1991: /__/ 95 percent /__/ _____ percent (no more than 100)

Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size	Income Levels
1	$_____
2	$_____

To be deleted
Per TN 93-5
SPA 93-24

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

_____ Applicable to all groups. _____ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____months	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1/]	Net income level for persons living in rural areas for _____months	Amount by which Column (4) exceeds limits specified in 42 CFR
/_/ urban only				
/_/ urban & rural				
1	$	$	$	$
2	$	$	$	$
3	$	$	$	$
4	$	$	$	$
For each additional person, add	$	$	$	$

1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007 1/	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 1/
/_/ urban only				
/_/ urban & rural				
5	$	$	$	$
6	$	$	$	$
7	$	$	$	$
8	$	$	$	$
9	$	$	$	$
10	$	$	$	$
For each additional person, add:	$	$	$	$

1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

INCOME LEVELS (Continued)

E. Optional Groups Other Than the Medically Needy

1. Institutionalized Individuals Under Special Income Levels as follows:

Individuals with income below **300**% of the SSI Federal Benefit Rate for an individual living in his own home with no income.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

4. Aged and Disabled Individuals

☑ Same as SSI resource levels.

☑ More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	

☑ Same as medically needy resource levels (applicable only if State has a medically needy program)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

/_/ Except those specified below under the provisions of section 1902(f) of the Act.

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

For each additional person

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED BY MEDICAID OR ANY THIRD PARTY

CITATION
435.725(C) (4) (ii)

A deduction will be allowed from an individual's income for incurred expenses for medical or remedial care that are not subject to payment by a third party, including (1) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and (2) medically necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

The State sets reasonable limits as follows:

A deduction for expenses incurred for medically necessary non-covered medical or remedial care will be allowed based on the lesser of the Medicaid rate, the Medicare rate, or reasonable and customary charges.

A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of current application.

The deduction for medical and remedial care expenses that were incurred as the result of a transfer penalty period is limited to zero.

A deduction for initial or replacement dentures will be allowed for those meeting Agency established medical necessity criteria.

A deduction for hearing aids will be allowed for those meeting Agency established medical necessity criteria.

Revision: HCFA-AT-85-3 (BERC) SUPPLEMENT 3 TO ATTACHMENT 2.6-A
FEBRUARY 1985

State: _____

RESOURCE LEVELS FOR THE MEDICALLY NEEDY

_____ Applicable to all groups

Family Size	Resource level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
For each additional person	

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

OMB No.:
0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

STATE ALABAMA
STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

Payment Category (Reasonable Classification)	Administered By Federal / State	Gross Income Indivi- dual	Gross Income Couple	Payment Level Indivi- dual	Payment Level Couple	Income Disregards Employed
(1)	(2)	(3)		(4)		(5)
*Living in home with personal or nursing care						The disregard of the SSI Program
Living Arrangement "A"						
Individual--Level 1	X	300% of		60		
Level 2	X	SSI FBR		56		
Nursing Care	X			60		
Couple--Level 1	X		300% of		120	
Level 2	X		SSI FBR x 2		112	
Nursing Care	X				120	
Living Arrangement "B"						
Individual--Level 1	X	300% of		60		
Level 2	X	SSI FBR		56		
Nursing Care	X			60		
Couple--Level 1	X		300% of		120	
Level 2	X		SSI FBR x 2		112	
Nursing Care	X				120	
Living in Foster Care with personal or nursing care						
Individual	X	300% of		110		
Couple	X	SSI FBR	300% of SSI FBR x 2		220	
**Cerebral palsy treatment center						
Individual	X	300% of SSI FBR	300% 0f SSI FBR x 2	196		
Couple	X				392	

*Needs considered and payment made are in addition to SSI FBR
**Disabled only
(Level 1 Bedfast & Chairfast) (Level 2 Ambulatory)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT*

/ / Section 1902(f) State /X/ Non-Section 1902(f) State

The consideration of in-kind support and maintenance in the income calculation is waived for determining eligibility of individuals and couples as Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries.

Fluctuating income may be averaged for the past six months and projected for twelve months for determining eligibility of individuals and couples as Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries.

Income will not be deemed from parents to pregnant women in determining the eligibility of individuals as pregnant women, infants, and children with income under the Federal Poverty Level.

For children under age 19 covered under the provisions of section 1902(a)(10)(A)(ii)(I), the following more liberal income methodologies are used to determine eligibility:

- All applicants and recipients with earnings will receive the earned income disregard of $30 and a 1/3 of the remainder for 12 consecutive months.

- Net income for self-employment and farming will be calculated using Schedule C and Schedule F respectively.

- $1 will be disregarded for all applicants and recipients.

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT*

___ Section 1902(f) State _X_ Non-Section 1902(f) State

Federal and State tax refunds and refundable tax credits are excluded as income for the following eligibility groups:

_X_ Qualified children and pregnant women 1902(a)(10)(A)(i)(III).

_X_ Poverty level pregnant women and infants (133 –185% FPL) under 1902(a)(10)(A)(i)(IV).

_X_ Poverty level children aged 1 up to age 6 (133% FPL) under 1902(a)(10)(A)(i)(VI).

_X_ Poverty level children aged 6 up to age 19 (100% FPL) under 1902(a)(10)(A)(i)(VII).

_X_ Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below.

Children receiving adoption subsidy payments under 1902 (a)(10)(A)(ii)(VIII)

Adolescents in state foster care under 1902 (a)(10)(A)(ii)(I)

Individuals receiving state supplementary payment based on need under 1902 (a)(10)(A)(ii)(XI)

NOTE: *The Special Income Level Group under 1902(a)(10)(A)(ii)(V), the Individuals Who Would be Eligible if In an Institution Group under 1902(a)(10)(A)(ii)(VI) and the Hospice Group under 1902(a)(10)(A)(ii)(VII) cannot be included in this disregard.*

____ Medically Needy under 1902(a)(10)(C)(i)(III).

_____ All aged, blind or disabled groups in 209(b) states under 1902(f).

_X_ QMBs, SLMBs and QIs under 1905(p),

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:. ALABAMA .

LESS RESTRICTIVE METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

. X . For all eligibility groups not subject to the limitations on payment explained in Section 1903(f) of the Act*: All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

*Less restrictive methods may not result in exceeding gross income limitations under Section 1903(f).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902 (R) (2) OF THE ACT

( ) Section 1902 (f) State (X) Non-Section 1902 (f) State

The following are more liberal resource requirements than SSI for determining eligibility of individuals under the provision of 42-CFR 435.211 and 435.236.

All resources of the applicant and spouse of the applicant are excluded for the QMB, SLMB, QI-1 and QI-2 cases.

Interest and dividend income is excluded for QMB, SLMB, QI-1 and QI-2 cases.

The consideration of life estate interest in real property is waived for the institutional type cases.

Personal effects such as clothing, jewelry, furniture, etc. are excluded up to $4000 for the institutional type cases.

The required net annual income of 6 percent is waived for the excluded $6000 in equity value in income-producing property essential to self-support for the institutional type cases.

The cash value of life insurance policies with combined face value of $5000 or less is excluded for institutional type cases.

The burial fund exclusion is $5000 for institutional type cases.

Commingling of burial funds is allowed for institutional type cases.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

Medicaid will not consider resources of a person equal to the amount of long-term care insurance benefit payments in determining Medicaid eligibility when the long-term care insurance policy covers at least the first three years of nursing home care and/or home health care services.

The exclusion shall be for the life of the purchaser provided he or she maintains obligations pursuant to the long-term care insurance policy.

Insurance benefit payments made on behalf of a claimant, for payment of long-term care services, shall be considered to be expenditures of resources as required for eligibility for medical assistance to the extend that the payments are all of the following:

(1) For services Medicaid approves or covers for its recipients.

(2) In an amount not in excess of the charges of the health services provider.

(3) For nursing home care and/or home health care services.

(4) For services provided after the person meets the coverage requirements for long-term care benefits established by the agency for this program.

For children under age 19 covered under the provisions of section 1902(a)(10)(A)(ii)(I), all resources are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2) 1917(b)(1)(C) The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

Institutionalized individuals

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

__X__ The Alabama Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the Alabama Department of Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the Alabama Department of Insurance.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

- The policy was issued no earlier than the effective date of this State Plan amendment.

- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.

- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

- Alabama does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.

- The Alabama Department of Insurance assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

- The Agency provides information and technical assistance to the Alabama Department of Insurance regarding the training described above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alabama

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services {section 1905(a)(7)}

Home and community care for functionally disabled and elderly adults {section 1905(a)(22)};

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which medical assistance is otherwise under the agency plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

___ the first day of the month in which the asset was transferred;

_X_ the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

_X_ The average monthly cost of a private patient of nursing facility services in the agency;

___ The average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

X does not impose a penalty;

___ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

X does not impose a penalty;

___ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap--
The agency:

X totals the value of all assets transferred to produce a single penalty period;

____ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--
The agency:

X assigns each transfer its own penalty period;

___ uses the method outlined below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

* Any remaining penalty period will be divided equally between the two spouses beginning the month the Community Spouse becomes Medicaid eligible as an institutional or home and community based waiver services recipient.

* If there is an odd number of months remaining in the penalty period the spouse institutionalized first will serve a penalty one month longer than the other spouse.

* The total penalty imposed on both spouses cannot exceed the length of the penalty originally imposed on the individual.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

___ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

___ For transfers of individual income payments, the agency will impose partial month penalty periods.

_X_ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

___ The agency uses an alternate method to calculate penalty periods, as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURTIY ACT

State: ALABAMA

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship --
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

Upon a determination of a transfer of assets for less than fair market value that requires imposition of a transfer penalty the Agency will:

1. Send written notices which informs the individual and authorized representative (if one) of the transfer penalty; and

2. Send a copy of the Administrative Code Rule 560-X-25-.09 which informs the individual and authorized representative of the right to request an undue hardship exemption; and

3. Send a copy of the notice which informs the individual and authorized representative (if one) of the right to appeal the decision made by the Alabama Medicaid Agency.

4. The written request for an undue hardship exemption must be received by Medicaid within 60 days from the date the notice of action is mailed. The District Office will gather all pertinent information/documentation and forward to the Central Office with an interpretation request form.

5. The appropriate Director of Beneficiary Services will review all pertinent information/documentation to determine if the criteria for an undue hardship exemption have been met.

6. The individual and authorized representative (if one) will be notified in writing within 45 days of receipt of the request for exemption of the Agency's determination of whether undue hardship criteria have been met. If the undue hardship exemption is denied, another copy of Administration Code Rule 560-X-25-.09 and another copy of the notice of appeal rights will be sent.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

7. Upon notification by the individual or authorized representative (if one) of a request to appeal a denial of an undue hardship exemption a fair hearing will be scheduled in accordance with chapter three of the Alabama Medicaid Agency's Administrative Code.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

In situations where an individual has admitted that an asset has been transferred for less than fair market value for the purpose of obtaining Medicaid benefits the Agency may still grant an exemption from the transfer of asset penalty where the individual demonstrates by clear and convincing evidence that the imposition of such a penalty will cause the individual to suffer undue hardship. Undue hardship will only be considered in extreme cases where the individual has been denied admission to or discharged from an institutional facility or denied home and community based waiver services which are necessary to preserve the individual's life. Undue hardship does not exist where a transfer penalty causes an individual to experience inconvenience or would cause an individual to restrict their lifestyle but would not place the individual at serious risk of being deprived of care of services necessary to sustain life.

In determining the existence of undue hardship the Agency will consider all circumstances involving the transfer and the situation of the individual, including, but not limited to, the following:

1. Whether the individual has been determined to be a person in need of care and protection pursuant to the Adult Protective Services Act, Code of Alabama 1975, section 38-9-1, et seq.

2. Whether the individual or his representative has exhausted all reasonable efforts to obtain a return of or compensation for the transferred asset, including voiding the transfer pursuant to Code of Alabama 1975, section 35-1-2 or section 8-9-12, or pursuing any other criminal or civil action available to recover the asset; and

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

3. Whether the individual was defrauded of the transferred asset, which is documented by a court action or an official police report; and

4. Whether the individual or his representative has exhausted all reasonable efforts to meet the individual's needs from other available sources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

1917(c) FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services;

   Nursing facility level of care provided in a medical institution;

   Home and community-based services under a 1915(c) or (d) waiver.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

2. Non-institutionalized individuals:

_____ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

___ The State uses the first day of the month in which the assets were transferred

_X_ The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

_X_ the average monthly cost to a private patient of nursing facility services in the State at the time of application;

___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care--

Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income—

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

TRANSFER OF ASSETS

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

____ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed_____ days (may not be greater than 30).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

The agency does not apply the trust provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

Upon a determination that application of the trust provisions will result in the denial of eligibility, the agency will:

1. Send written notices which inform the individual and authorized representative (if one) of the denial; and

2. Send a copy of Administrative Code Rules 560-X-25-.06 and 560-X-25-.09 which informs the individual and authorized representative (if one) that an undue hardship exemption policy exists; and

3. Send a copy of the notice which informs the individual and authorized representative (if one) of the right to appeal the decision made by the Alabama Medicaid Agency.

4. Upon receipt of a request (within 60 days after the date the agency's notice is received) from the individual or authorized representative (if one) for an exemption because of undue hardship, the agency will determine if an undue hardship exemption should be granted. The District Office will gather all pertinent information/documentation and forward to the Central Office with an interpretation request form.

5. The Central Office Certification Support Division Director, the Policy Unit Coordinator, and the Agency Legal Counsel will review all pertinent information/documentation to determine if the criteria for an undue hardship exemption has been met.

6. The individual and authorized representative (if one) will be notified in writing (within 45 days of receipt of the request for exemption) upon a determination of whether undue hardship criteria has been met. If the undue hardship exemption is denied, another copy of Administrative Code Rules 560-X-25-.06 and 560-X-25-.09, and another copy of the notice of appeal rights will be sent.

7. Upon notification by the individual or authorized representative (if one) of a request to appeal a denial of an undue hardship exemption, a fair hearing will be scheduled in accordance with chapter three of the Alabama Medicaid Agency's Administrative Code.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

The following criteria will be used to determine whether the agency will not apply the trust provisions because doing so would work an undue hardship:

In situations where an individual has admitted that a trust has been established for the purpose of obtaining Medicaid benefits, the agency may still grant an exemption from the application of the trust provisions where the individual demonstrates by clear and convincing evidence that the imposition of such a penalty will cause the individual to suffer undue hardship. Undue hardship will only be considered in extreme cases where the individual has been denied admission to or discharged from an institutional facility or denied home and community based waiver services which are necessary to preserve the individual's life. Undue hardship does not exist where a denial of eligibility causes an individual to experience inconvenience or would cause an individual to restrict their lifestyle but would not place the individual at serious risk of being deprived of care of services necessary to sustain life.

In determining the existence of undue hardship the agency will consider all circumstances involving the trust and the situation of the individual, including, but not limited to, the following:

1. Whether the individual has been determined to be a person in need of care and protection pursuant to the Adult Protective Services Act, Code of Alabama 1975, section 38-9-1, et seq.

2. Whether the individual or his representative has exhausted all reasonable efforts to obtain a return of the assets in the trust, including voiding the trust pursuant to Code of Alabama 1975, section 35-1-2 or section 8-9-12, or pursuing any other criminal or civil action available to recover the asset in the trust; and

3. Whether the individual was defrauded by the creation of the trust which is documented by a court action or an official police report; and

4. Whether the individual or his representative has exhausted all reasonable efforts to meet the individual's needs from other available sources, including the beneficiaries of the trust.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

Citation	Condition or Requirement

COST EFFECTIVENESS METHODOLOGY FOR
COBRA CONTINUATION BENEFICIARIES

1902(u) of the Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

_____ The methodology as described in SMM section 3598.

_____ Another cost-effective methodology as described below.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ALABAMA

RESOURCE DETERMINATION UNDER SECTION 1902(r)(2) OF THE ACT AS AMENDED BY THE MCCA OF 1988 AND SECTION 1905(P) OF THE ACT INCLUDED BY THE TAX TECHNICAL AMENDMENT TO THE MCCA ALLOWS USE OF MORE LIBERAL POLICIES FOR QUALIFIED MEDICARE BENEFICIARIES.

The following are more liberal resource requirements than SSI for determining eligibility of individuals as Qualified Medicare Beneficiaries only.

The consideration of personal effects such as clothing, jewelry, furniture, etc., as a countable resource is waived.

The consideration of a life interest and/or remainder interest in real property is waived.

The required net annual income of 6 percent is waived for the excluded $6,000.00 in equity value in income-producing property essential to self-support.

Two automobiles may be excluded regardless of value.

Case value of life insurance policies with combined face value less than $2500 is excluded.

Burial exclusion is increased from $1500 to $2500.

Commingling of burial funds is allowed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ALABAMA

RESOURCE DETERMINATION UNDER SECTION 1902(r)(2) OF THE ACT AS ALLOWS USE OF MORE LIBERAL POLICIES FOR AGED, BLIND AND DISABLED INDIVIDUALS ELIGIBLE UNDER THE PROVISIONS OF 42 CFR 435.211 AND 435.231.

The following are more liberal resource requirements than SSI for determining eligibility of individuals eligible under the provisions of 42 CFR 435.211 and 435.231:

The required net annual income of six (6) percent is waived for the excluded $6,000.00 in equity value in income-producing property essential to self-support.

Two automobiles may be excluded regardless of value.

The consideration of a life estate interest and/or remainder interest in real property is waived.

Personal effects such as clothing, jewelry, furniture, etc., are excluded up to $4,000.

Case value of life insurance policies with combined face value less than $2500 is excluded.

Burial exclusion is increased from $1500 to $2500.

Commingling of burial funds is allowed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

ELIGIBILITY UNDER SECTION 1925 OF THE ACT
TRANSITIONAL MEDICAL ASSISTANCE

The State covers low-income families and children for Transitional Medical Assistance (TMA) under section 1925 of the Social Security Act (the Act). This coverage is provided for families who no longer qualify under section 1931 of the Act due to increased earned income, or working hours, from the caretaker relative's employment, or due to the loss of a time-limited earned income disregard. **(1902(a)(52), 1902(e)(1)(B), and 1925 of the Act)**

The amount, duration, and scope of services for this coverage are specified in Section 3.5 of this State plan.

For Medicaid eligibility to be extended through TMA, families must have been Medicaid eligible under section 1931 (months of retroactive eligibility may be used to meet this requirement):

__X__ During at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931.

____ For fewer than 3 of the 6 previous months immediately preceding the month in which the family became ineligible under section 1931. Specify:

The State extends Medicaid eligibility under TMA for an initial period of:

____ 6 months. For TMA eligibility to continue into a second 6-month extension period, the family must meet the reporting, technical, and income eligibility requirements specified at section 1925(b) of the Act.

__X__ 12 months. Section 1925(b) does not apply for a second 6-month extension period.

The State collects and reports participation information to the Department of Health and Human Services as required by section 1925(g) of the Act, in accordance with the format, timing, and frequency specified by the Secretary and makes such information publicly available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Alabama

SECTION 1924 PROVISIONS

A. Income and resource eligibility policies used to determine eligibili ty for institutionalized individuals who have spouses living in the community are consistent with Section 1924.

B. In the determination of resource eligibility the State resource standard $ 12,000. **Effective 10-1-89 thru 12-31-89.**
12,516 **Effective 1-1-90.**
25,000 **Effective 4-1-90.**

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

Undue hardship exists when the Agency determines by clear and convincing evidence that the institutionalized spouse lacks the right, authority, or power to access the excess countable resources attributed to such spouse under §1924 (c)(2), and ineligibility for Medicaid benefits will result in non-receipt of necessary medical services.

In determining the existence of "undue hardship" Medicaid will consider all circumstances involving the situation of the individual, including but not limited to the following:

1. Whether the individual or his/her representative has exhausted all reasonable efforts to obtain and utilize the resources in question; or

2. Whether the individual or his/her representative has exhausted all reasonable efforts to meet his/her needs from all other available sources; or

3. Whether the individual has been determined to be a person in need of care and protection pursuant to the Adult Protective Services Act, Alabama Code (1975) §38-9-1, et seq.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

ASSET VERIFICATION SYSTEM

1940(a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
(2) The system cannot be based on mailing paper-based requests.
(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

ASSET VERIFICATION SYSTEM

2. System Development

___ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

_X_ B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

___ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

___ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

___ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

In order to implement the requirements of an Asset Verification System (AVS), the Alabama Medicaid Agency will select a contractor through the Request for Information (RFI) process. The contractor will have the capacity, requisite experience and expertise to provide the AVS services for the state of Alabama, in accordance with the provisions and requirements set forth in Section 1040 of P.L. 110-252. The contactor will ensure the quality of services provided, take necessary steps to make any corrections noted timely and will meet or exceed specific and measurable performance standards as outlined in the RFI. The system will comply with the national standards prescribed by the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 and will be kept in compliance with new and modified requirements.

Alabama will prepare and issue an RFI in July 2013 for the purpose of identifying qualified vendors and gaining an understanding of the cost and system changes that will be necessary to implement in AVS.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ALABAMA

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

__X__ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

_____ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____.

_____ This higher standard applies statewide.

_____ This higher standard does not apply statewide. It only applies in the following areas of the State:

_____ This higher standard applies to all eligibility groups.

_____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

Revision: MSA-PI-75-3
August 20, 1974

Attachment 2.6-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Alabama

STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

I. Aged, blind, and disabled recipients of optional State supplementary payments are eligible for medical assistance as categorically needy under this plan. The payments meet the four conditions specified in 45 CFR 248.2(d), that is, they are:

A. Regular, in cash, and based on need;

B. Available on a Statewide basis;

C. Made to reasonable classifications of individuals who, except for the level of their income, would be eligible for an SSI payment, as described in the supplement to this ATTACHMENT; and

D. Equal to the difference between income and the financial standard used to determine eligibility for the supplement.

II. There are variations in the payment levels by political subdivisions.

☒ No.

☐ Yes, as described below:

Rec'd. 1-6
Trans. A- 1/29/75
Analyst Init. 1/1/74
Obsoleted by Date

SUPPLEMENT TO ATTACHMENT 2.6-B - STATE-ADMINISTERED OPTIONAL STATE SUPPLEMENT: PAYMENT GROUPS: NEED & PAYMENT LEVELS: ADDITIONAL DISREGARDS: ADDITIONAL ELIGIBILITY CRITERIA

State Alabama

COVERAGE GROUPS	MAXIMUM NEEDS CONSIDERED		MAXIMUM PAYMENT		ADDITIONAL DISREGARDS	MORE RESTRICTIVE ELIGIBILITY CRITERIA		
	Aged and Disabled	Blind	Aged and Disabled	Blind	Aged, Blind, and Disabled	Aged	Disabled	Blind
Cerebral palsy treatment center -								
Individual	$392 1/		$392		None	None	None	None
Couple	784 1/		784		None	None	None	None
*Living in home with personal care -								
Individual	40	40	40	40	None	None	None	None
Couple	80	80	80	80	None	None	None	None
**Living in home with personal care -								
Individual	60	60	60	60	None	None	None	None
Couple	120	120	120	120	None	None	None	None

1/ Disabled only

*Effective 5/1/81 Needs considered and payment made are in addition to SSI FBR.

**Effective 7/1/81 Needs considered and payment made are in addition to SSI FBR.

5/27/81 81-10 5/1/81 A-6/15/81 Eff 5/1/81

SUPPLEMENT TO ATTACHMENT 2.6-B - STATE-ADMINISTERED OPTIONAL STATE SUPPLEMENT: PAYMENT GROUPS: INCOME LEVELS: ADDITIONAL DISREGARDS: ADDITIONAL ELIGIBILITY CRITERIA

MEDICAL INSTITUTIONS AND INTERMEDIATE CARE FACILITIES
State: Alabama

Payment Categories					Additional disregard	More Restrictive Eligibility Criteria
1	2	3	4	5	6	7
	Individual		Couple			
Aged-Blind-Disabled	Gross	Net	Gross	Net		
Skilled Nursing Facility Mental Hospital Tuberculosis Hospital	300% of SSI SPA $794.10	$794.10	-	-	none	
Intermediate Care Facility and Intermediate Care Facility for the Mentally Retarded	300% of SSI SPA $794.10	$794.10	-	-	none	

Effective October 1, 1981

Rec'd 11/6/81 81-17 11/3/81
R.O. A 11/18/81 EH 10/1/82
Obj

State/Territory: Alabama

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: /X / No limitations /__/ With limitations* **

2.a. Outpatient hospital services.

   Provided: /X / No limitations / / With limitations* **

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic. (Which are otherwise included in the State Plan). ##

   / X/ Provided: / / No limitations / X/ With limitations* **

   / / Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: / / No limitations / X/ With limitations* **

   d. This item deleted as per HCFA-PITN-MCD-4-92

3. Other laboratory and x-ray services.

   Provided: /__/ No limitations / X/ With limitations* **

##Via HCFA-PITN-MCD-4-02
#Limitations are the same as defined in 2.c above.

**Additional medically necessary services beyond limitations are covered for children under 21 years of age referred through the E.P.S.D.T. Program.

*Description provided on attachment.

Limitation of Services

1. **Inpatient Hospital Services other than those provided in an Institution for Mental Diseases.**

Additional medically necessary services beyond limitations are covered for children under 21 years of age that are eligible for E.P.S.D.T. services.

Covered inpatient hospital services are inclusive of services performed by hospital based Certified Registered Nurse Anesthetists (CRNAs).

Inpatient Hospital services are provided without limitations and in accordance with 42 CFR 440.10.

Limitation of Services

2.a. **Outpatient Hospital Services**

Additional medically necessary services beyond limitations are covered for children under 21 years of age that are eligible for E.P.S.D.T. services

Covered outpatient hospital services are inclusive of services performed by hospital based Certified Registered Nurse Anesthetists (CRNAs).

Outpatient hospital services are provided in accordance with 42 CFR 440.20.

Limitations of Service

2.b. Rural Health Clinic Services

Additional medically necessary services beyond limitations are covered for children under 21 years of age that are eligible for E.P.S.D.T. services.

Effective Date: 10/01/93
Rural Health Clinic Services and Other Ambulatory Services furnished by a Rural Health Clinic. (Which are otherwise included in the State Plan).

Services covered under the Rural Health Clinic Program (Independent and Provider-Based Rural Health Clinics) are any medical services typically furnished by a physician in an office or in a physician home visit. Services provided by a Rural Health Clinic may be provided by a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, clinical psychologist, or clinical social worker. Each recipient is limited to 14 medical visits per calendar year as described in numbered item 5a of Attachment 3.1-A.

In Independent Rural Health Clinics, other ambulatory services (dental services, eyeglasses, hearing aids, prescribed drugs, prosthetic devises, and durable medical equipment are not defined as Rural Health Clinic services but are covered separately under the reimbursement practice utilized in other settings under the State Plan.

Other ambulatory services provided in Provider-Based Rural Health Clinics are covered as clinic services.

Limitations of Services

2.c. Federally Qualified Health Center Services

Additional medically necessary services beyond limitations are covered for children under 21 years of age that are eligible for E.P.S.D.T. services.

Effective Date: 10/01/93
Federally Qualified Health Center (FQHC) Services and Other Ambulatory Services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Services provided by an FQHC include services provided by a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, clinical social worker, and services and supplies incidental to such services as would otherwise be covered if furnished by a physician as an incidental to a physician service. Any other ambulatory services offered by the center which are included in the State Plan are covered. Each recipient is limited to 14 medical visits per calendar year as described in numbered item 5a of Attachment 3.1-A.

Dental services, family planning, prenatal, and EPSDT encounters in FQHC's are limited as described in Attachment 3.1-A in the State Plan.

Inpatient services provided by FQHC's are limited as described in numbered item 5b of Attachment 3.1-A.

Limitation of Services

3. **Other laboratory and x-ray services.**

Effective Date: 01/01/94
Professional component of clinical lab services is reimbursable only if ordinarily performed by the physician and directly contributes to diagnosis or treatment of an individual patient.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: /_/ No limitations /X/ With limitations* **

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Provided: /_/ No limitations /X/ In excess of Federal requirements* **

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: /_/ No limitations /X/ With limitations* **

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing## facility or elsewhere .

Provided: /_/ No limitations /X/ With limitations* **

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: /_/ No limitations /X/ With limitations* **

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

/X/ Provided:/_/ No limitations /X/ With limitations* **

/_/ Not provided.

##Via HCFA-PITN-MCD-4-92
**Additional medically necessary services beyond limitations are covered for children under 21 years of age referred through the E.P.S.D.T. Program.

*Description provided on attachment.

4. **Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.**

Effective Date: 04/01/91

a. Nursing Facility Services for Individuals 21 years of Age and Older must be prior authorized. Prior Authorization will be based on medical necessity.

Services included in basic (covered) nursing home charges.

(1) All nursing services to meet the total needs of the patient including treatment and administration of medications ordered by the physician.

(2) Personal services and supplies for the comfort and cleanliness of the patient. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the resident to maintain a clean, well-kept personal appearance.

(3) Room (semi-private or ward accommodations) and board, including special diets and tubal feedings necessary to provide proper nutrition. This includes feeding residents unable to feed themselves.

(4) All services and supplies for incontinent residents.

(5) Bed and bath linens, including linen savers such as cellupads, and diapers.

(6) Nursing and treatment supplies as ordered by the resident's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, sterile and non-sterile dressings, special dressings (such as ABD pads and pressure dressings) intravenous administration sets, normal intravenous fluids (such as glucose, D5W, D10W).

(7) Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, and other items generally provided by nursing facilities for the general use of all residents.

(8) Sterile and non-sterile dressings and medications for prevention and treatment of bed sores.

4. **Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age and older. (Continued)**

Effective Date: 10/01/93

4.a. (9) Medically necessary Over-the-Counter (non-legend) drug products prescribed or ordered by a physician.

(10) Personal apparel laundry services.

4.b. **Early and periodic screening, diagnosis and treatment services for individuals under 21 years of age, and treatment of conditions found.**

Effective Date: 04/01/90

(1) Screening schedules will be in accordance with those described for well-child care in the Guidelines for Health Supervision of American Academy of Pediatrics. Periodic screenings are recommended at ages: 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, 18 years, and 20 years.

Interperiodic screenings will be covered when medically necessary for other necessary health care, diagnostic services and treatment to correct or ameliorate defects, and physical and mental illnesses and conditions.

The State will inform all Medicaid eligible recipients under twenty-one (21) years of age about the EPSDT Program.

Effective Date: 04/01/90

(2) Vision Services. Periodic visual services shall include at least one comprehensive eye examination and eyeglasses each calendar year. Additional subjective screenings and interperiodic examinations and eyeglasses are available as needed when medically necessary to diagnose, ameliorate and treat defects in vision.

Effective Date: 04/01/90

(3) Dental Services. A complete oral examination including prophylaxis and fluoride treatment are authorized every six calendar months. Routine dental services are covered. Additional subjective, standard, and interperiodic dental screenings are available as needed, and without limitations when medically necessary to diagnose, ameliorate, treat and correct abnormal oral conditions.

4.b. **Early and periodic screening, diagnosis and treatment services for individuals under 21 years of age, and treatment of conditions found. --- (Continued)**

Effective Date: 04/01/90

(4) Hearing Services. Periodic hearing services shall include at least one comprehensive audiological test each calendar year. Additional subjective screenings and interperiodic examinations are available as needed when medically necessary to diagnose, ameliorate and treat defects in hearing.

Effective Date: 01/01/92

(5) Unlimited coverage is provided for medically necessary health care, diagnostic, treatment and/or other measures which are necessary to correct or ameliorate defects, physical and mental illnesses and conditions discovered during or as a result of an EPSDT screening, whether or not such services exceed benefit limits stated in the State Plan. The following services are covered under the State plan if provided as a result of an EPSDT referral: chiropractic, Christian Science, occupational therapy, physical therapy, podiatry, private duty nursing, psychology, speech-language-hearing therapy and transplants (heart-lung, pancreas-kidney and lung), air ambulance, and personal care services.

Effective Date: 01/01/90

(6) Eyeglasses. One pair of glasses per calendar year is authorized for recipients eligible for treatment under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Additional eyeglasses may be provided when medically necessary and supported by medical documentation.

Effective Date: 10/01/91

(7) Adolescent Pregnancy Prevention educational services are performed only by a qualified provider 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: 04/01/2012

(8) Medicaid Services Provided in Schools - Individuals receiving Medicaid services in schools have freedom of choice of qualified licensed providers as established in 1902(a)(23) of the Act. Individuals also have the right to receive Medicaid services outside of the school setting.

103.5.1 Audiology Services
Service Description: Audiology services documented in the IEP include, but are not limited to evaluations, tests, tasks and interviews to identify hearing loss in a student whose auditory sensitivity and acuity are so deficient as to interfere with normal functioning.

Professional Qualifications:
Audiology services must be provided by:

- A qualified audiologist who meets the requirements of, and in accordance with, 42 CFR §440.110(c), and other applicable state and federal law or regulation;

- A licensed/certified audiology assistant when the services are provided in a school setting and when these providers are acting under the supervision or direction of a qualified Audiologist in accordance with 42 CFR §440.110 and other applicable state or federal law.

103.5.2 Occupational Therapy
Service Description: Occupational Therapy services documented in the IEP include, but are not limited to:

1. Evaluation of problems which interfere with the student's functional performance
2. Implementation of a therapy program or purposeful activities which are rehabilitative, active or restorative as prescribed by a licensed physician.

These activities are designed to:

a. improve, develop or restore functions impaired or lost through illness, injury or deprivation,
b. improve ability to perform tasks for independent functioning when functioning is impaired or lost,

c. prevent, through early intervention, initial or further impairment or loss of function,
d. correct or compensate for a medical problem interfering with age appropriate functional performance.

Professional Qualifications:

- Must be licensed by the Alabama State Board of Occupational Therapy and meet the requirements of, and in accordance with, 42 CFR §440.110(b);
- Occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an OT. Occupational therapy assistants must have an Associate of Arts degree and must be licensed by the Alabama State Board of Occupational Therapy. Supervision of certified OT assistants must include one-to-one on-site supervision at least every sixth (6th) visit. Each supervisory visit must be documented and signed by the OT making the visit.

All services must be performed within the scope of services as defined by the licensing board.

103.5.3 Physical Therapy

Service Description: Physical Therapy services documented in the IEP include, but are not limited to:

1. Evaluations and diagnostic services
2. Therapy services which are rehabilitative, active, restorative. These services are designed to correct or compensate for a medical problem and are directed toward the prevention or minimization of a disability, and may include:
    a. developing, improving or restoring motor function
    b. controlling postural deviations
    c. providing gait training and using assistive devices for physical mobility and dexterity
    d. therapeutic exercises and procedures.

Professional Qualifications: Must be licensed by the Alabama Board of Physical Therapy and meet the requirements of, and in accordance with, 42 CFR §440.110(a). Physical therapy assistants may provide services only under the supervision of a qualified physical therapist. PT assistants must be licensed by the Alabama Board of Physical Therapy. Supervision of licensed PT assistants must include one-to-one on-site supervision at least every sixth (6th) visit. Each supervisory visit must be documented and signed by the PT.

All services must be performed within the scope of services as defined by the licensing board.

103.5.4 Counseling Services

Service Description:
Counseling services are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and for whom the services are medically necessary. Medically necessary EPSDT services are health care, diagnostic services, treatment, and other measures described in section 1905(a) of Title XIX of the Social Security Act and, 42 CFR 440.130, that are necessary to correct or ameliorate any defects and physical and mental illnesses and conditions. These services are intended for the exclusive benefit of the Medicaid eligible child, documented in the IEP, and include but are not limited to:

1. Services may include testing and/or clinical observations as appropriate for chronological or developmental age. Such services are provided to:

    a. Assist the child and/or parents in understanding the nature of the child's disability;
    b. Assist the child and/or parents in understanding the special needs of the child;
    c. Assist the child and/or parents in understanding the child's development

2. Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. Qualified professionals may incorporate the following examples as a form of service. These examples are also recognized by the American Psychological Association as a therapeutic form of service. Qualified providers can determine the type of modalities that can be utilized based on the condition and treatment requirements of each individual and are not limited to these examples.

    A. Cognitive Behavior Modification- This is a therapeutic approach that combines the cognitive emphasis on the role of thoughts and attitudes influencing motivations and response with the behavioral emphasis on changing performance through modification of reinforcement contingencies.

    B. Rational-emotive therapy- A comprehensive system of personality change based on changing irrational beliefs that cause undesirable, highly charged emotional reactions such as severe anxiety.

C. Pyschotherapy- Any of a group of therapies, used to treat psychological disorders, that focus on changing faulty behaviors, thoughts, perceptions, and emotions that may be associated with specific disorder. Examples include. individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non-verbal communication, family therapy and sensory integrative therapy.

3. Assessing needs for specific counseling services.

Professional Qualifications:
Counseling services may be provided by:

- Licensed Psychologist;
- Licensed Psychological Associate;
- Licensed Certified Social Worker;
- Licensed Marriage and Family Therapist;
- Licensed Professional Counselor;
- Licensed Psychiatrist
- Registered nurse who has completed a master's degree in psychiatric nursing;
- Licensed School Psychologist when the services are provided in a school setting; or
- Licensed Specialist in School Psychology when the services are provided in a school setting.

103.5.5 Personal Care Services
Service Description:

EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions.

Personal care services are support services furnished to a client who has physical, cognitive or behavioral limitations related to the client's disability or chronic health condition that limit the client's ability to accomplish activities of daily living ADLs), instrumental activities of daily living (IADLs), or health-related functions. Personal care services provided to students on specialized transportation vehicles are covered under this benefit. Services must be authorized by a physician in accordance with a plan of treatment or (at the State's option) in accordance with a service plan approved

by the State. Personal care services may be provided in an individual or group setting, and must be documented in the IEP/IFSP.

Professional Qualifications:

Individuals providing personal care services must be a qualified provider in accordance with 42 CFR *5* 440.167, who is 18 years or older, has a high school diploma or GED, and has been trained to provide the personal care-services required by the client. Training is defined as observing a trained employee on a minimum of three patients and verbalization of understanding the personal care service. When competence cannot be demonstrated through education and experience, individuals must perform the personal assistance tasks under supervision.

Personal care services will not be reimbursed when delivered by someone who is a legally responsible relative or guardian. Service providers include: individual attendants, attendants employed by agencies that meet the state requirements. Special education teachers and special education teacher's aides can qualify as personal care worker. They must demonstrate the services they are providing meet the personal care service definition that the personal care service is documented in the IEP, and their services are to assist the student is accomplishing ADL and IADL and not activities that support education or instruction.

103.5.6 Speech/Language Services

Service Description: Speech/language therapy services documented in the student's IEP include, but are not limited to:

1. Diagnostic services
2. Screening and assessment
3. Preventive services
4. Corrective services

Speech therapy services may be provided in an individual, group or family setting. The number of participants in the group should be limited to assure effective delivery of service.

Professional Qualifications:
Speech and language services must be provided by:

- A qualified speech/language pathologist (SLP) who meets the requirements of, and in accordance with, 42 CFR §440.110(c), and other applicable state and federal law or regulation;

- American Speech-Language-Hearing Association (ASHA) certified SLP with Alabama license and ASHA-equivalent SLP (i.e., SLP with master's degree and Alabama license) when the services are provided in a school setting; or

- A provider with a state education agency certification in speech language pathology or a licensed SLP intern when the services are provided in a school setting and when these providers are acting under the supervision or direction of a qualified SLP in accordance with 42 CFR §440.110 and other applicable state or federal law.

All services must be performed within the scope of services as defined by the licensing board.

103.5.7 Nursing Services

Service Description:
Nursing services outlined in this section of the state plan are available to Medicaid eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary, and these services must be documented in the IEP/IFSP.

Nursing services are defined as the promotion of health, prevention of illness, and the care of ill, disabled and dying people through the provision of services essential to the restoration of health.

Professional Qualifications:
The Licensed Practical Nurse and Registered Nurse shall be licensed but the State of Alabama to provide the services and practice within the Alabama Board of Nurse Examiners. Nursing services must be provided by a qualified nurse who meets qualification requirements of, and in accordance with, 42 CFR 440.60 and, on a restorative basis, under 42 CFR 440.130(d), including services delegated in accordance with the Alabama Board of Nurse Examiners to individuals who have received appropriate training from a RN , including nursing services delivered by advanced practice nurses (APNs) including nurse practitioners (NPs) and clinical nurse specialists (CNSs), registered nurses (RNs), licensed vocational nurses (LVNs), licensed practical nurses (LPNs).

103.5.8 Specialized Transportation Services

Service Description:
Specialized transportation services include transportation to receive Medicaid approved school health services. This service is limited to transportation of covered, authorized services in an IEP or IFSP.

1) The special transportation is Medicaid reimbursable if:
   a. It is provided to a Medicaid eligible EPSDT child who is a student in a public school in Alabama;

b. It is being provided on a day when the child receives a prior authorized covered service;
c. The student's need for specialized transportation services is documented in the child's plan of care, IEP or IFSP; and
d. The driver has a valid driver's license

2) Specialized transportation services are defined as transportation that requires a specially equipped vehicle, or the use of specialized equipment to ensure a child is taken to and from the child's residence to school or to a community provider's office for prior authorized related services:

a. Medical Services provided in School: Transportation provided by or under contract with the school, to and from the students place of residence, to the school where the student receives one of the health related services covered by Title XIX;
b. Medical Service provided off- site: Transportation provided by or under contract with the school from the students place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by the Title XIX;

i. Transportation from school to the offsite service and back to school is reimbursable. No home to school transportation is reimbursed when the ride is from school to the medical service and back to school.
ii. Transportation from school to the offsite medical service and to home is reimbursable if the offsite medical appointment takes place and it is not feasible to return to school in time for child to be transported back home.

3) Specialized transportation services will not be Medicaid reimbursable if the child does not receive a Medicaid covered service on the same day. When claiming these costs as direct services, each school district is responsible for maintaining written

documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

4) In cases where Personal Care Services are provided as part of the Specialized Transportation Service for a student, the cost of this service is covered under the Personal Care Services benefit described in Section 103.5.5; provided that the personal care service provider meets the qualifications defined in this section.

4.c. **Family planning services and supplies for individuals of child-bearing age.**

Effective Date: 07/01/93

(1) Family planning services are limited to those services and supplies that prevent or delay pregnancy.

(2) The initial/annual physical examination visit is limited to one visit every 365 days. Lab services such as hemoglobin/hematocrit and urine check (dipstick) are included in the visit. The initial family planning visit is limited to one per provider per recipient.

(3) Routine laboratory screening tests such as syphilis, gonorrhea culture, and Pap smear tests are covered only when provided during the initial/annual physical examination visit.

(4) Periodic revisits are limited to no more than four (4) visits in a calendar year.

(5) The family planning home visit is limited to one visit during the 60-day post partum period.

(6) For recipients selecting the implant method of contraception, one physical examination with counseling is authorized prior to the implant procedure.

(7) Sterilization procedures are limited to recipients meeting federal requirements for coverage, including the requirement to be at least twenty-one (21) years of age at the time of informed consent.

Tobacco Cessation Counseling Services for Pregnant Women

4. d 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

_X_ (i) By or under supervision of a physician; and

_X_ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or*

___ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*describe if there are any limits on who can provide these counseling services

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: __ No limitations _X_ With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt should be explained below.

Please describe any limitations:

The State's benefit package will consist of a minimum of four (4) face-to-face tobacco cessation counseling sessions to pregnant women per year.

5a. **Physician's services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. All physician services that an optometrist is legally to perform are included in physicians' services under this plan and are whether furnished by a physician or an optometrist.**

1. Physician visits in offices, hospital outpatient settings, and nursing facilities. Within each calendar year each recipient is limited to no more than a total of 14 physician visits in offices, hospital outpatient settings, and nursing facilities. Visits counted under this quota will include, but not be limited to, visits for: prenatal care, postnatal care, family planning, second opinions, consultations, referrals, psychotherapy (individual, family, or group), and care by ophthalmologists for eye disease. Physician visits provided in a hospital outpatient setting that have been certified as an emergency do not count against the physician benefit limit of 14 per calendar year. Each limit can be exceeded based upon medical necessity.

2. Physician visits to hospital inpatients. In addition to the 14 physician visits referred to in paragraph a. above, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider. Each limit can be exceeded based upon medical necessity.

3. Psychiatric evaluations or testing. These are covered services when medically necessary and given by a physician in person. Psychiatric evaluations or tests are limited to one per recipient, per physician, per calendar year. These visits are counted as part of the yearly quota of 14. Each limit can be exceeded based upon medical necessity.

4. Psychotherapy visits. These are covered services when medically necessary and given by a physician in person. These visits are counted as part of the yearly quota of 14. Each limit can be exceeded based upon medical necessity.

5a. Physician's services whether furnished in the office, the patient's home, ahospital, a nursing facility or elsewhere. (Continued)

Effective Date: 01/01/2021

7. Eyecare. Two complete eye examinations and work-ups for refractive error areauthorized per calendar year for recipients eligible for treatment under the
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Additionalexaminations are provided by prior authorization from the Alabama Medicaid Agencybased on medical necessity. Visits for complete eye examinations do not count under the current office visit limitation.

One complete eye examination and work-up for refractive error every two calendar years is authorized for all other Medicaid recipients. Visits for these purposes will notbe counted under the current visit limitation. Additional examinations are provided byprior authorization from the Alabama Medicaid Agency based on medical necessity. Visits for complete eye examinations do not count under the current office visit limitation.

Effective Date: 11/01/75

8. Orthoptics. Orthoptics may be prior authorized by the Alabama Medicaid Agencywhen medically necessary.

9. Out-of-State-Care. Except for those services which require prior approval as stated elsewhere in this State Plan (i.e. transplants, and select surgeries) medical care outsidethe state of Alabama will not require prior authorization by the Alabama Medicaid Agency.

Effective Date: 11/01/75

11. Prior authorized services. These are subject to all limitations of the Alabama MedicaidProgram.

12. Ancillary services: When performed by the physician, or by his staff under his supervision, can be billed by the physician without an office visit. (Example: Druginjection, laboratory and X-ray.)

5b. Medical and surgical services furnished by a dentist (in accordance withsection 1905(a)(5)(B) of the Act).

Effective Date: 01/01/92
Medical and surgical care not related to teeth which is provided by a dentist is included inthe physician visit limits as state in 5a above.

6. **Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.**

6.a **Podiatrists Services**

Effective Date: 01/01/92
Podiatrists' Services are provided only for E.P.S.D.T. eligible children under the age of 21.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.
/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

c. Chiropractors' services.
/ X/ Provided: / / No limitations / X/ With limitations*

/ / Not provided.

d. Other practitioners' services.
/ X/ Provided: Identified on attached sheet with description of limitations, if any.

/ / Not provided.

7. Home health services.

Effective Date: 01/01/92

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: / / No limitations / X/ With limitations*
**

Effective Date: 01/01/92

b. Home health aide services provided by a home health agency.

Provided: / / No limitations / X/ With limitations*
**

Effective Date: 01/01/92

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: / / No limitations / X/ With limitations*
**

**Additional medically necessary services beyond limitations are covered for children under 21years of age referred through the E.P.S.D.T. Program.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

8. Private duty nursing services.

/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

*Description provided on attachment.

Limitation of Services

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued).

b. **Effective Date: 10/01/2011**
Optometrists' Services

Optometrists' services are not provided.

Effective Date: 01/01/92

c. **Chiropractors' services**

Chiropractors' services are provided only for E.P.S.D.T. referred children under the age of 21.

Effective Date: 10/01/00

d. **Other Practitioners' Services**

(1) Anesthesia services provided by qualified Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) are covered services.

Effective Date: 10/01/18

(2) Applied Behavior Analysis services provided by a Licensed Behavior Analyst, a Licensed Assistant Behavior Analyst under the supervision of a Licensed Behavior Analyst, or by an unlicensed Registered Behavior Technician under the supervision of a Licensed Behavior Analyst or Licensed Assistant Behavior Analyst within the scope of their practice as defined by state law are covered for E.P.S.D.T. referred children under the age of 21. The scope of practice defined by state law for a Licensed Behavior Analyst and a Licensed Assistant Behavior Analyst permits supervision of an unlicensed Registered Behavior Technician. The licensed practitioner assumes professional responsibility for the services provided by an unlicensed Registered Behavior Technician or an Assistant Behavior Analyst. Claims must be submitted by the Licensed Behavior Analyst.

Limitation of Services

1905(a)(6): Other Licensed Practitioner

6. **Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued).**

Effective Date: 11/01/2010

(3) Neonatal and Women's Health Care Nurse Practitioner Services: Providers in these programs are limited to Registered Nurses who are certified as neonatal, or women's health care nurse practitioners.

Effective Date: 07/01/19

(4) A nurse practitioner who is employed and reimbursed by a facility that receives reimbursement from Alabama Medicaid Program for services provided by the nurse practitioner shall not bill separately if these services are included in the reimbursement made to that facility through its cost report (e.g.., hospitals, rural health clinics, etc.).

Effective Date: 11/02/2009

(5) Pharmacists: The Alabama Medicaid Agency will make payment for the administration of vaccine by a pharmacist who is employed by a pharmacy participating in the Alabama Medicaid Program.

Limitation of Services

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Initial teaching activities will be limited to four months.

Effective Date: 06/01/11
In-Home Monitoring

In-home nursing services are utilized to place telemetric equipment in the home for the monitoring and reporting to the attending physician of the status of diabetes, hypertension, and congestive heart failure. Readings of blood pressure, pulse, glucose, and/or weight measurements are transmitted via telephone to a secure centralized database.

b. Home health aide services provided by a home health agency.

Effective Date: 02/09/89
Home health care benefits are increased to entitle eligible recipients to receive up to 104 home health visits per calendar year. Skilled nurse and home health aide visits run concurrently.

Effective Date: 06/01/11
Additional skilled nursing visits and home health aide visits are limited to EPSDT and must be prior authorized once the recipient has exceeded 104 home health visits in a calendar year.

Effective Date: 01/01/88
Home health care services within the Alabama Medicaid program must meet requirements of Federal Regulations 42 CFR 440.70. All records of home health services provided are subject to review for approval based on medical necessity and services limitations.

Aide visits are limited to two per week. No additional visits will be authorized.

7. **Home Health Services - Continued**

c. Medical supplies, equipment, and appliances suitable for use in the home.

Effective Date: 10/01/90
Additional supplies, appliances, and medical equipment suitable for use in the home may be provided only after prior authorization by the Alabama Medicaid Agency is obtained. The attending physician must submit a written request for medical items that would provide appropriate non-experimental services as a cost-effective alternative to institutional care.

Effective Date: 11/23/76
Medical supplies, equipment, and appliances (suitable for use in the home) as prescribed by the attending physician are limited to those items listed in the Alabama Medicaid Home Health Care Manual.

Effective Date: 10/01/86
Items of durable medical equipment require prior authorization from the Alabama Medicaid Agency. Prior authorization will be based on medical necessity.

d. Physical therapy, occupational therapy, or speech audiology services provided by a home health agency or medical rehabilitation facility.

Effective Date: 06/01/11
Physical therapist and occupational therapist shall meet the licensing and certification requirements referenced in CFR 440.110.

Effective Date: 01/01/92
Physical therapy, occupational therapy, or speech pathology services provided by a home health agency are only for children under 21 through the EPSDT Program.

8. **Private Duty Nursing Services**

Effective Date: 01/01/92
Private duty nursing services are provided only for children under 21 referred through the EPSDT Program and prior authorized through Alabama Medicaid Agency.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Effective Date: 01/01/84

9. Clinic services.

/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

10. Dental services.

/X / Provided: /_/ No limitations /X / With limitations*

/_/ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

b. Occupational therapy.

/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

*Description provided on attachment.

State Plan under Title XIX of the Social Security Act

State/Territory: Alabama

Section 1905(a)(9) Clinic Services

The state provides coverage for this benefit as defined at section §1905(a)(9) of the Social Security Act (the Act) and 42 C.F.R. 440.90 and as described as follows:

General Assurances

[Select all three checkboxes below.]

- [x] The state assures services are furnished by a facility that is not part of a hospital in accordance with 42 C.F.R. 440.90.
- [x] The state assures that services are furnished by facilities that are organized and operated to provide medical care to outpatients in accordance with 42 C.F.R. 440.90.
- [x] The state assures that services are furnished under the direction of a physician or dentist in accordance with 42 C.F.R. 440.90(a).

Types of Clinic Services and Limitations in Amount, Duration, or Scope

[Select if applicable, describe below, and indicate if limits may be exceeded based upon state determined medical necessity criteria.]

- [ ] Limitations apply to all services within the benefit category.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act

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Section 1905(a)(9) Clinic Services

Types of Clinics and Services:

[**Select all that apply and describe below as applicable]**

☑ Behavioral Health Clinics **[Describe the types of behavioral health clinics below and select below if applicable.]:**

Mental Health Services will be provided only by qualified Mental Health Service Providers. Participation will be based on the provider's proven ability to furnish the following complete range of Mental Health Services.

☑ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

(1) Counseling/Psychotherapy
(a) Individual Therapy: a face-to-face contact between the Medicaid eligible client and one or more mental health professionals for the purpose of providing non-residential intake, diagnostic, and treatment services on both a scheduled and unscheduled basis.
(b) Family Therapy: a face-to-face contact with one or more Medicaid eligible members of a family for the purpose of altering family influences that contribute to the disorder of one or more Medicaid eligible family members.
(c) Group Therapy: a face-to-face contact with one or more Medicaid eligible clients and one or more mental health professionals for the purpose of resolving difficulties and effecting therapeutic changes through group interaction.
(2) Medication Checkup: a face-to-face contact with a Medicaid eligible client by the appropriate staff team member for the purpose of reviewing

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State Plan under Title XIX of the Social Security Act

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Section 1905(a)(9) Clinic Services

the client's medication regimen and attendant overall functioning.
(3) Prehospitalization Screening Services: Diagnostic and prognostic clinical screening when hospitalization is requested or definitely considered; to assure that less restrictive alternative services are also considered and made available, and utilized, when appropriate.
(4) Diagnostic Assessment: A specialized service for intensive clinical evaluation and formal reports.
(5) Day Treatment: A milieu treatment program which is goal oriented and has the expectation that the client will improve. Clients must be actively involved in individual or group therapy. The day treatment service must be available 20 hours per week in one location, unless waived by DMH.

☐ IHS and Tribal Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria].**

☐ Renal Dialysis Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

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☑ Other Clinics **[Describe the types of clinics, if any limitations apply, and select below if applicable.]:**

(1) Clinic services provided by eligible prenatal clinic providers.
(a) Participation will be based on the provider meeting one of the following:
(1) Receives funds under the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act); or
(2) Participates in a state perinatal program.
(b) Prenatal Clinic services include antepartum care plus one (1) postpartum visit {six (6)-week checkup}.

(2) Clinic services provided by children's specialty clinic providers. Participation will be based on the provider's proven ability to meet the following criteria:
(a) Clinic services are specialty oriented and provided by an interdisciplinary team to children who are eligible for EPSDT services and are experiencing developmental problems.
(b) Disciplines include at a minimum, specialty physicians, physician assistants, psychologists, nurses, service coordinators/social workers, physical therapists, audiologists, nutritionists, speech/language pathologists.
(c) Services offered must include a plan for medical and habilitative services to children with special health care needs as well as coordination and support services.
(d) Children's specialty clinic providers must have a signed written agreement with the Alabama Medicaid Agency to provide services to children eligible for EPSDT services.

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Section 1905(a)(9) Clinic Services

(e) All children's specialty clinic services must be furnished by or under the direction of a physician.

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

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Four Walls Exceptions

The state assures that the following services may be furnished outside of the clinic. **[Select the first and second checkbox; Do not select the second checkbox if the state does not enroll IHS or Tribal facilities as providers of clinic services.]:**

☑ Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address in accordance with 42 C.F.R. 440.90(b).

☐ Services furnished outside a clinic that is a facility of the Indian Health Service, whether operated by the Indian Health Service (IHS) or by a Tribe or Tribal organization (as authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638), by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(c).

The state elects to cover the following services outside of the clinic **[Select all that apply.]:**

☐ Services furnished outside of a clinic that is primarily organized for the care and treatment of outpatients with behavioral health disorders, including mental health and substance use disorders, by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(d) **[Describe the types of behavioral health clinics such exception applies to below.]:**

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☐ Services furnished outside of a clinic that is located in a rural area and is not a rural health clinic (as referenced in section §1905(a)(2)(B) of the Act and 42 C.F.R. 440.20(b) of this subpart) by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(e) **[Select one of the checkboxes below and describe the definition of a rural area that applies to this exception.]:**

☐ A definition adopted and used by a federal governmental agency for programmatic purposes **[Describe below.]:**

☐ A definition adopted by a state governmental agency with a role in setting state rural health policy **[Describe below.]:**

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The state attests that **[Select the checkbox if the state elects to cover services outside of a clinic that is located in a rural area.]:**

☐ The selected definition of a rural area best captures the population of rural individuals that meets more of the four criteria that mirror the needs and barriers to access experienced by individuals who are unhoused:

- The population experiences high rates of behavioral health diagnoses or difficulty accessing behavioral health services;
- The population experiences issues accessing services due to lack of transportation;
- The population experiences a historical mistrust of the health care system; and
- The population experiences high rates of poor health outcomes and mortality.

Additional Benefit Description (Optional)

At its option the state may provide additional descriptive information about the benefit, beyond what is included in the federal statutory and regulatory definitions and descriptions. **[Describe below.]:**

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Limitation of Services

10. **Dental Services**

Effective Date: 01/01/92
Dental services are provided for E.P.S.D.T. eligible children under the age of 21.

Effective Date: 10/01/22
All medically necessary preventive, restorative, diagnostic, periodontal, endodontic, oral surgery, and emergent dental procedures are covered for pregnant Medicaid recipients.

11. **Physical Therapy and Related Services**

Effective Date: 01/01/92

a. **Physical therapy services** are provided only for E.P.S.D.T. referred children under the age of 21.

Effective Date: 01/01/92

b. **Occupational therapy services** are provided only for E.P.S.D.T. referred children under the age of 21.

Effective Date: 01/01/92

c. **Services for individuals with speech, hearing, and language disorders** provided by or under the supervision of a speech pathologist are provided only for E.P.S.D.T.
referred children under the age of 21.

Services for individuals with speech, hearing, and language disorders provided by or under the supervision of an audiologist, are provided only for E.P.S.D.T. eligible children under the age of 21.

Effective Date: 02/01/99

Evaluation for use and/or fitting of voice prosthetics or augmentative communication devices to supplement oral speech when provided by or under the supervision of a speech pathologist is covered for recipients of any age.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: /_/ No limitations /X/ With limitations* **

/_/ Not provided.

b. Dentures.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Prosthetic devices.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

d. Eyeglasses.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

**Additional medically necessary services beyond limitations are covered for children under 21 years of age referred through the E.P.S.D.T. Program.

*Description provided on attachment.

Limitation of Services

12. **Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

a. **Prescribed Drugs**

12. **Effective Date: 07/01/91**

(1) General Coverage

Medicaid covers only drugs of participating manufacturers which have entered into and comply with an agreement under Section 1927(a) of the Act which are prescribed for a medically accepted condition. Because of an extenuating circumstance waiver, drugs were covered from non-participating manufacturers through 3-31-91. Single source or innovator multiple source drugs classified by the Food and Drug Administration as 1A are covered if a rebate agreement has not been signed with the manufacturer if the state has made a determination that the availability of the drug is essential to the health of beneficiaries under the State Plan for Medical Assistance and the physician has requested and received prior approval in advance of its dispensing..

Effective Date: 01/01/06

(2) Medicaid will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

Medicaid provides coverage, for all pharmacy eligible Medicaid recipients, including full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit (Part D), for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 CFR 423.104 (f) (l) (ii) (A).

Excluded Drugs

The following outpatient drugs or classes of drugs, or their medical uses are excluded from coverage or otherwise restricted, unless noted:

(a) Agents when used for anorexia, weight loss, or weight gain except for those specified by the Alabama Medicaid Agency.

- Selective covered outpatient drugs for all eligible beneficiaries will be covered as listed on the state's website.

(b) Agents when used to promote fertility except for those specified by the Alabama Medicaid Agency.

- Selective covered outpatient drugs for all eligible beneficiaries will be covered as listed on the state's website.

Effective Date: 10/01/13

(c) Agents when used for the symptomatic relief of cough and cold.

Limitation of Services

12. **Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

a. **Prescribed Drugs**

(d) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations and others as specified by the Alabama Medicaid Agency.

- Selective covered outpatient drugs for all eligible beneficiaries will be covered as listed on the state's website.

(e) Selective non-prescription covered outpatient drugs for all eligible beneficiaries will be covered as listed on the state's website.

(f) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

Limitation of Services

12. **Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

12. a. **Prescribed Drugs**- Continued

(3) **Reduction in Coverage**

The number of outpatient pharmacy prescriptions for all recipients except as specified below is limited to four brand name/five total drugs per month per adult recipient effective October 1, 2013. Anti-psychotic, anti-retroviral, and anti-epileptic agents may be paid up to ten prescriptions per month. Drugs dispensed in the Long Term Maintenance Supply program are exempt from the monthly prescription limit. Prescriptions for Medicaid eligible recipients under age 21 in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and prescriptions for Medicaid eligible nursing facility residents are excluded from these limitations.

Overrides will be granted only in cases in which the prescribing physician documents medical necessity for the recipient to be switched from a product in one of the below named classes to a product within the same therapeutic class in the same calendar month. The first product must have been covered by Medicaid. State coverage may be allowed through overrides of up to ten prescriptions per month for drugs classified by American Hospital Formulary Services (AHFS) or First Data Bank (FDB) Therapeutic Class as Antineoplastic Agents, Antiarrhythmic Agents, Cardiotonic Agents, Miscellaneous Vasodilating Agents, Miscellaneous Cardiac Agents, Nitrates and Nitrites, Alpha Adrenergic Blocking Agents, Beta Adrenergic Blocking Agents, Dihydropyridines, Miscellaneous Calcium Channel Blocking Agents, Diuretics, Angiotensin-Converting Enzyme Inhibitors, Angiotensin II Receptor Antagonists, Mineralocorticoid (Aldosterone) Receptor Antagonists, Central Alpha Agonists, Direct Vasodilators, Peripheral Adrenergic Inhibitors, Miscellaneous Hypotensive Agents, Hemostatics, Calcium Replacements, Electrolyte Depleters, Immunosuppresives, Alpha Glucosidase Inhibitors, Amylinomimetics, Biguanides, Dipeptidyl Peptidase-4 Inhibitors, Incretin Mimetics, Insulins, Meglitinides, Sulfonylureas, Thiazolidinediones, and Miscellaneous Diabetic Agents.

(4) **Coverage of New Drugs**

Except for excluded drugs listed in (2) above, Medicaid covers all new drugs after FDA approval and upon notification by the manufacturer of the new drug.

(5) **Confidentiality**

Medicaid regards information disclosed by the manufacturers or wholesalers as confidential and will not disclose such information in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs as required in Section 1927 (b)(3)(D).

(6) **Reporting**

The state will report to each manufacturer not later than 60 days after the end of each calendar quarter and in a form consistent with the standard format established by the Secretary, utilization data on the total number of dosage units for each covered outpatient drug dispensed during a quarter and shall promptly transmit a copy of the report to the Secretary.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed Drugs – Continued

(7) Auditing by Manufacturer

The state permits manufacturers to audit utilization data as stated in (6) above. Adjustments to rebates are made to the extent that information indicates that utilization was greater or less than previously specified.

(8) Prior Approval

The state provides for response by telephone or other communication devices, e.g., fax, within 24 hours of a request for prior approval and provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation.

(9) Supplemental Rebate Agreements

The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

The state may negotiate brand and/or generic supplemental rebates and value/outcome(s)-based agreement in addition to the federal rebates provided for in Title XIX. Supplemental drug rebate agreements and value/outcome(s)-based agreement between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

A supplemental drug rebate agreement between the state and a drug manufacturer for drugs provided to the Alabama Medicaid population, originally submitted to CMS on August 8, 2003, and an updated version submitted on December 1, 2015, entitled, “State of Alabama Supplemental Drug Rebate Contract,” has been authorized by CMS.

A value/outcome(s)-based model agreement between the state and a drug manufacturer for drugs provided to the Alabama Medicaid population, originally submitted to CMS on July 1, 2019, and an updated version submitted on December 1, 2020 entitled, “State of Alabama Value/Outcome(s) Based Agreement,” has been authorized by CMS.

Supplemental rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.

All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement.

(10) Preferred Drug List

Pursuant to 42 U.S.C. section 1396r-8 the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization will be provided with a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency situations as in accordance with provisions of section 1927(d)(5) of the Social Security Act.

Prior authorization will be established for certain drug classes or particular drugs in accordance with federal law.

All drugs covered by the program irrespective of a prior authorization requirement will comply with the provisions of the national drug rebate agreement.

The state will utilize the Drug Utilization Review board to assure that in addition to pricing consideration, preferred drugs are clinically appropriate.

13. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed Drugs - Continued

(11) Long Term Maintenance Supply

The State reimburses for each three month supply of Agency designated maintenance medication dispensed to recipients. A maintenance medication is an ordered/prescribed medication generally used to treat chronic conditions or illnesses and taken regularly and continuously. The following criteria apply to the three month supply:

a. The medications will be designated by the Agency.
b. The three month supply medications listing(s) will be available to the public on the State's website: www.medicaid.alabama.gov.
c. The recipient will demonstrate 60 days of stable therapy prior to the State reimbursing the provider for dispensing a three month supply.
d. An opt out program for recipients who may not be candidates for maintenance supplies will be available.

12. Prescribed drugs, dentures, and prosthetic devices; and eye-glasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

Effective Date: 01/01/92

12.b. Dentures prescribed as medically necessary are provided for children under 21 referredthrough the EPSDT Program.

12.c. Prosthetic Devices

(1) Internal life-supporting prostheses such as pacemaker and Smith-Peterson Nail arecovered.

Effective Date: 01/01/90

(2) Contact lenses are provided only by prior authorization from the Alabama MedicaidAgency and based on medical necessity.

(3) Prosthetic lenses and artificial eyes which are necessary in the treatment or diseases of theeye.

(4) Prosthesis and the services of a qualified doctor of dentistry in connection with the fabrication of the prosthesis for closure of a space within the oral cavity created byremoval of a lesion or congenital defect such as cleft palate.

Effective Date: 01/01/92

(5) Prosthetic devices prescribed as medically necessary are provided for children under 21referred through the EPSDT Program.

Effective Date: 03/01/08

(6) Basic level prosthetic, orthotic, and pedorthic devices are provided for adults between theages of 21 and 65 only by prior authorization from the Alabama Medicaid Agency and based on medical necessity.

12.d. Eyeglasses

Effective Date: 01/01/21

(1) Two pairs of glasses or more if medically necessary per calendar year for recipients eligible for treatment under the Early and Periodic Screening, Diagnosis and Treatment(EPSDT) program. These limitations also apply to prescribing, dispensing, fitting, and adjusting of eyeglasses. All limitations can be exceeded by prior authorization for medical necessity when supported by medical documentation.

(2) One pair of glasses per two calendar years for all recipients 21 years of age and older.These limitations also apply to prescribing, dispensing, fitting, and adjusting of eyeglasses. Additional eyeglasses and changes in lenses may be provided by prior authorization, when medically necessary and supported by medical documentation.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

Effective Date: 01/01/92
a. Diagnostic services.
/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

Effective Date: 01/01/92
b. Screening services.
/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

Effective Date: 10/01/91
c. Preventive services.
/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

Effective Date: 01/01/92
d. Rehabilitative services.
/ X/ Provided: /_/ No limitations / X/ With limitations*
**
/_/ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

Effective Date: 10/01/95
a. Inpatient hospital services.
/ X/ Provided: /_/ No limitations / X/ With limitations*

/_/ Not provided.

**Additional medically necessary services beyond limitations are covered for children under 21 years of age referred through the E.P.S.D.T. Program.
*Description provided on attachment.

Effective Date: 01/01/94

13. **Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.**

Effective Date: 01/01/92

13.a. **Diagnostic Services**

Other diagnostic services are provided only for children under 21 referred through the EPSDT Program.

13.b. **Screening Services**

Other screening services are provided only for children under 21 referred through the EPSDT Program.

13.c. **Preventive Services**

(1) Other preventive services for children are provided only if children under 21 are referred through the EPSDT Program.

Effective Date: 10/01/23

(2) The state assures coverage for approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration, without cost sharing. The state also assures that changes to ACIP recommendations will be incorporated into coverage and billing codes as necessary.

Effective Date: 10/01/18

13.d. **Rehabilitative services** will be provided to Medicaid recipients as recommended by a physician or other licensed practitioner on the basis of medical necessity. Although limits are provided for guidance, the limitation(s) noted can be exceeded based on medical necessity. While it is recognized that involvement of the family in the treatment of individuals with mental illness or substance use disorders is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified recipient's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified recipient's treatment needs are not covered by Medicaid. An asterisk denoting this restriction will appear in each service description that makes reference to a recipient's collateral defined as a family member, legal guardian or significant other. Rehabilitation services that are delivered face to face can either be in person or via telemedicine/telehealth, as approved by the Alabama Medicaid Agency.

To participate in the Alabama Medicaid Program, rehabilitative services providers must meet the following requirements. Service providers must demonstrate that they meet the criteria in either (1), (2), or (3), and both (4) AND (5) below.

1. A provider must be certified as a 310-board community mental health center by DMH and must have demonstrated the capacity to provide access to the following services through direct provision or referral arrangements:
   - Inpatient services through referral to community hospitals and through the attending physician for community hospitalizations.
   - Substance abuse services including intensive outpatient services and residential services.
   - Services are not provided in an institution for mental diseases (IMD).
   - Must submit an application to and receive approval from DMH to provide mental health rehabilitative services under the Medicaid Rehabilitative Option program.

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**
Effective Date: 10/01/23

2. For the provision of Substance Abuse Rehabilitative Services an entity:
   - Must be an organization that is currently certified by the Alabama Department of Mental Health (DMH) to provide alcohol and other drug treatment services; and
   - Must submit an application to and receive approval by DMH to provide Substance Abuse Rehabilitative Services under the Medicaid Rehabilitative Option program.
3. The Department of Human Resources (DHR), the Department of Youth Services (DYS), Department of Mental Health (DMH) for ASD and the Department of Children's Services (DCS) are eligible to be rehabilitative services providers for children under age 21 if they have demonstrated the capacity to provide an array of medically necessary services, either directly or through contract.
   Additionally, DHR may provide these services to adults in protective service status. At a minimum, this array includes the following:
   - Individual, group, and family counseling
   - Crisis intervention services
   - Consultation and education services
   - Case management services Assessment and evaluation
4. A provider must demonstrate the capacity to provide services off-site in a manner that assures the recipient's right to privacy and confidentiality and must demonstrate reasonable access to services as evidenced by service location(s), hours of operation, and coordination of services with other community resources.
5. A provider must ensure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to an adequate array of services delivered in a flexible manner to best meet their needs. Medicaid does not cover all services listed above, but the provider must have demonstrated the capacity to provide these services.

Services must be provided by practitioners who meet the following qualifications:

Rehabilitative Services Professionals are defined as the following:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- An associate licensed counselor under Alabama law
- An independent Clinical social worker licensed under Alabama law
- A licensed master social worker
- A marriage and family therapist licensed under Alabama law
- A marriage and family therapist associate licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- A Masters Level Clinician is an individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other human service field areas and is under the
- supervision of a master's level or above clinician with two years of postgraduate clinical experience.

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**
Effective Date: 10/01/23

- QSAP I (Substance Abuse): A Qualified Substance Abuse Professional I (QSAP I) shall consist of: (i) An individual licensed in the State of Alabama as a: (I) Professional Counselor, Graduate Level Social Worker, Psychiatric Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Marriage and Family Therapist, Clinical Psychologist, Physician's Assistant, Physician; or (ii) An individual who: (I) Has a master's Degree or above from a nationally or regionally accredited university or college in psychology, social work, counseling, psychiatric nursing, or other behavioral health area with requisite course work equivalent to that of a degree in counseling, psychology, social work, or psychiatric nursing, and *(II) Has successfully completed a clinical practicum or has six month's post master's clinical experience; and *(III) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of date of hire.
- Professional Autism Services Specialist I (PASS I) shall consist of: (i)An individual licensed in the State of Alabama as a (1) Professional Counselor, Graduate Level Social Worker, Registered Nurse, Marriage and Family Therapist, Clinical Psychologist, Physician; or (ii) An individual who (1) Has a Master's Degree or above from a nationally or regionally accredited university or college in psychology, counseling, social work, or other behavioral health area with requisite course work equivalent to that degree in counseling, psychology, or social work.

Other Eligible Service Providers:

- A physician licensed under Alabama law.
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners .
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses or a multistate licensure privilege.
- Qualified Mental Health Provider – Bachelor's – A person with a Bachelor's Degree in a human services field.
- Qualified Mental Health Provider – Non-Degreed – A person with a high school diploma or GED supervised by a Rehabilitative Services Professional or Registered Nurse (RN).
- A Pharmacist licensed under Alabama state law.
- A Registered Nurse licensed under Alabama state law or a multistate licensure privilege.
- A Practical Nurse licensed under Alabama state law or a multistate licensure privilege.
- Occupational Therapist licensed under Alabama state law.
- Speech Therapist licensed under Alabama state law.
- Certified Autism Support Specialist (CASS) -Non-Degreed- A person with a high school diploma or GED supervised by a Professional Autism Services Specialist I or a Professional Autism Services Specialist II.
- Professional Autism Services Specialist II (PASS II) – An individual who has a Bachelor of Arts or Bachelor of Science in a human services related field from an accredited college or university with a minimum of one-year experience working with individuals with disabilities, families and/or service coordination
- A Nursing Assistant certified pursuant to Alabama State Law.
- A Certified Medical Assistant certified through the American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT).
- Medication Assistant Certified (MAC) Worker – A person working under a Medication Assistance Supervising (MAS) nurse that meets the Alabama Board of Nursing requirements.
- A Mental Health Certified Youth Peer Specialist - Youth who has personal experience with children and adolescent's mental health, who is willing to share his/her personal experiences, who has at least a high should diploma or GED, and who has satisfactorily completed a Mental Health Youth Peer Specialist training program approved by the state. Certified Mental Health Peer Specialist must be supervised by a Rehabilitative Services Professional.

13. **Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)**

13.d. **Rehabilitative services --- Continued**
Effective Date: 10/01/18

- A Mental Health Certified Adult Peer Specialist who has personal experience with recovery from mental illness, who is willing to share his/her personal experiences, who has at least a high should diploma or GED, and who has satisfactorily completed a Mental Health Peer Specialist training program approved by the state. A Certified Mental Health Adult Peer Specialist must be supervised by a Rehabilitative Services Professional.
- A Mental Health Parent Peer Support Specialist provider who is parenting or has parented a child experiencing a mental, emotional or behavioral health disorderand can articulate the understanding of their experience with another parent or family member. This individual may be a birth parent, adoptive parent, family member standing in for an absent parent, or other person chosen by the family or youth to have the role of parent. This individual has at least a high school diploma or GED, and has satisfactorily completed a Mental Health Parent Peer Support Provider training program approved by state. A Mental Health Parent Peer Support Specialist must be supervised by a Rehabilitative Services Professional.
- A Parent Autism Peer Support Specialist provider who is parenting or has parented a child with Autism Spectrum Disorder and can articulate the understanding of their experience with another parent or family member. This individual may be a birth parent, adoptive parent, family member standing in for an absent parent, or other person chosen by the family or youth to have the role of parent. This individual has at least a high school diploma or GED, and has satisfactorily completed an Autism Parent Peer Support Provider training program approved by state. A Parent Autism Peer Support Specialist must be supervised by a Rehabilitative Services Professional or a Professional Autism Services Specialist II.

    - A Child/Youth Autism Peer Support Specialist serves children and youth ages 0-21 and uses his/her life experience with ASD and specialized training to promote resiliency. Child/Youth Autism Peer Support service can be provided in an individual, family, or group setting by a Certified Child/Youth Autism Peer Support Specialist. A Child/Youth Peer Support Specialist must be supervised by a Rehabilitative Services Professional or a Professional Autism Services Specialist II.

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**
Effective Date: 10/01/23

- QSAP II shall consist of: (i) An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Is licensed in the State of Alabama as a Bachelor Level Social Worker; or (III) Has a Bachelor's Degree from a nationally or regionally accredited college or university in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (IV) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium or (V) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (VI) obtains a substance use counselor certification credential from the Alabama Association of Addiction Counselors, National Association Drug Abuse Association, or International Certification and Reciprocity Consortium within 30 months of hire, and (VII) participates in ongoing weekly supervision from an assigned QSAP 1 that is documented and appropriately filed in their personnel file for auditing purposes until counselor certification is obtained.
- QSAP III shall consist of: (i) An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Participates in ongoing supervision by a certified or licensed QSAP I for a minimum of one (1) hour individual per week until attainment of a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, or Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of hire.
- Qualified Paraprofessionals (QPP) shall have the following minimum qualifications: (i) A high school diploma or equivalent, and (ii) One (1) year of work experience directly related to job responsibilities and (iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.
- Certified Recovery Support Specialist (CRSS) must meet the following minimum qualifications: (i) Certified by ADMH as a Certified Recovery Support Specialist (CRSS) within six (6) months of date of hire, (ii) and has 2 years verified lived experience and (iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**
Effective Date: 01/01/18

- Senior Social Work Supervisor – Master's degree in Social Work from a social work program accredited by the Council on Social Work Education. Two years of professional social work experience in child welfare and/or adult services in a public welfare agency.

- Service Supervisor – Bachelor's degree from an accredited* four year college or university in any major AND three (3) years of professional social work experience in child protective services, adult protective services, child/adult foster care, and/or adoption operations OR Bachelor's degree from an accredited* four year college or university AND 30 semester or 45 quarter hours in social or behavioral science courses AND two (2) years of professional social work experience in child protective services, adult protective services, child/adult foster care, and/or adoption operations.
  - A Master's Degree in Social Work from a social work program accredited* by the Council on Social Work Education will substitute for one year of the required professional experience in child protective services, adult protective services, child/adult foster care, and/or adoption operations.

- Senior Social Worker - Master's degree in Social Work from a social work program accredited by the Council on Social Work Education. Eligibility for Licensure as issued by the Alabama Board of Social Work Examiners.

- Social Worker - Bachelor's degree in Social Work from a social work program accredited by the Council on Social Work Education. Eligibility for Licensure as issued by the Alabama Board of Social Work Examiners

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**
Effective Date: 10/01/23

- Social Service Caseworker- Bachelor's degree from an accredited* college or university in a social science OR a Bachelor's degree from an accredited* college or university with a degree in any major.

Covered Rehabilitative Behavior Health Services are as follows:

(1) Intake evaluation - An initial clinical evaluation of the recipient's request for assistance, presenting psychological and social functioning status, physical and medical condition, need for additional evaluation and/or treatment, and appropriateness for treatment of mental health or substance use disorders.

Eligible Provider Type:
- Rehabilitative Services Professional (all types)
- Social Services Caseworker

Billing Unit: Episode
Max Unit Limitations: Unlimited

(2) Medical Assessment and Treatment - Face-to-face contact with a recipient during which a qualified practitioner provides psychotherapy and/or medical management services. Services may include physical examinations, evaluation of co-morbid medical conditions, development or management of medication regimens, the provision of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services, or the provision of educational services related to management of a physical, mental health, or substance use disorder.

Eligible Provider Type:
- Physician
- Physician Assistant
- Licensed Certified Registered Nurse Practitioner (CRNP)

Billing Unit: 15 minutes

Maximum Units: 6 per day, 52 per year

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**
Effective Date: 10/01/18

(3) Diagnostic Testing - Administration of standardized objective and/or projective tests of an intellectual, personality, or related nature in a face-to-face interaction between the recipient and a qualified practitioner or through computer-administered test and interpretation of the test result to assist with a definitive diagnosis. Once the diagnosis has been confirmed, this information is used to guide proper treatment by the development of an individualized, person-centered treatment plan.

Eligible Provider Type:

- Rehabilitative Services Professional (licensed) operating within their scope of practice.

Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**

Effective Date: 10/01/23

(4) Crisis intervention - Immediate emergency intervention with a recipient, or the recipient's collateral* (in person or by telephone) to ameliorate a maladaptive emotional/behavioral reaction by the recipient. Service is designed to resolve crisis and develop symptomatic relief, increase knowledge of resources to assist in mitigating a future crisis, and facilitate return to pre-crisis routine functioning. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural and formal support systems; and referral to alternate services at the appropriate level.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- Licensed Registered Nurse
- Licensed Practical Nurse
- Certified Nursing Assistant
- Certified Medical Assistant
- Qualified Mental Health Provider – Bachelor's
- Social Service Caseworker
- Certified Mental Health Peer Specialist (Youth, Peer, and Parent)
- QSAP II
- QSAP III
- Certified Recovery Support Specialist (CRSS)
- PASS I
- PASS II

Billing Unit: 15 minutes
Maximum Units: 20 per day, 7,300 per calendar year

(5) Individual Counseling – The utilization of professional skills by a qualified practitioner to assist a recipient in a face-to-face, one-to-one psychotherapeutic encounter in achieving specific objectives of treatment or care for a mental health and/or a substance use disorder. Services are generally directed toward alleviating maladaptive functioning and emotional disturbances relative to a mental health and/or substance use disorder, and restoration of the individual to a level of functioning capable of supporting and sustaining recovery. Individual Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- QSAP II

Billing Unit: 1 unit/per hour
Maximum Units: 1 per day, 52 per year

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. --- (Continued)

13.d. Rehabilitative services --- Continued

Effective 10/01/18

(6) Family counseling - A recipient focused intervention that may include the recipient, his/her collateral*, and a qualified practitioner. This service is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental health and/or substance use disorder that interferes with the recipient's personal, familial, vocational, and/or community functioning.

Eligible Provider Type:

- Rehabilitative Service Professional (all types)
- QSAP II

Billing Unit: 1 episode = minimum of 60 minutes
Maximum Units: 1 episode per day, 104 per year

Billing Unit/Maximum Unit (Multiple Family Group):

MI: Billing Unit: 1 episode per recipient = minimum of 60 minutes
Maximum Units:
1 episode per day, 104 per year

SA: Billing Unit: 1 episode = minimum of 90 minutes
Maximum Units: 1 episode per day, 104 per year

(7) Group Counseling – The utilization of professional skills by a qualified practitioner to assist two or more recipients in a group setting in achieving specific objectives of treatment or care for mental health or substance use disorder. Services are generally directed toward alleviating maladaptive functioning and behavioral, psychological, and/or emotional disturbances, and utilization of the shared experiences of the group's members to assist in restoration of each participant to a level of functioning capable of supporting and sustaining recovery. Group Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic service strategies.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- QSAP II

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. --- (Continued)

13.d. Rehabilitative services --- Continued

Effective 10/01/23
Billing Unit/Maximum Unit:
MI: Billing Unit: 1 episode per recipient = minimum of 60 minutes
Maximum Units:
1 episode per day, 104 per year

SA: Billing Unit: 1 episode per recipient = minimum of 90 minutes
Maximum Units: 1 episode per day, 104 per year

(8) Medication Administration - Administration of oral or injectable medication under the direction of a physician, physician assistant, or certified registered nurse practitioner.

Eligible Provider Type:
- Licensed Registered Nurse
- Licensed Practical Nurse
- Certified Medical Assistant
- MAC Worker

Billing Unit: Episode
Maximum Units:3 per day

(9) Medication Monitoring - Face-to-face contact with a recipient for the purpose of reviewing medication efficacy, monitoring compliance with dosage instructions, educating the recipient and collateral* of the expected effect of specified medication, and/or identifying needed changes in the medication regimen.

Eligible Provider Type:
- Rehabilitative Services Professional (all types)
- Qualified Mental Health Provider – Bachelor's
- QSAP II
- QSAP III
- Licensed Registered Nurse
- Licensed Practical Nurse
- Pharmacist
- Certified Nursing Assistant
- Certified Medical Assistant

Billing Unit: 15 minutes
Maximum Units: 2 per day, 52 per year

13. **Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. --- (Continued)**

13.d. **Rehabilitative services --- Continued**
Effective 10/01/18

(10) Partial Hospitalization Program - A physically separate and distinct organizational unit that provides intensive, structured, active, clinical treatment, less than 24 hours, with the goal of acute symptom remission, immediate hospital avoidance, and/or reduction of inpatient length of stay, or reduction of severe persistent symptoms and impairments that have not responded to treatment in a less intensive level of care.

Component Services:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Individual, group, and family counseling
- Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, and problem solving; as opposed to basic living skills, such as money management, cooking, etc.)
- Medication administration
- Medication monitoring
- Psychoeducational services

Eligible Provider Type:

MI: The program must have a multi-disciplinary treatment team under the direction of a psychiatrist, certified registered nurse practitioner, or physician's assistant. The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, the treatment team will include a:

- Physician, Physician assistant, OR Licensed Certified Registered Nurse Practitioner (CRNP); and
- Rehabilitative Services Professional (all types); and
- Licensed practical nurse, and/or
- Qualified Mental Health Provider- Bachelor's OR Qualified Mental Health Provider – Non-Degreed OR Certified Adult Mental Health Peer Specialist

SA: The program must be staffed and have a program coordinator as specified in current and subsequent revisions of regulations established for this service by the Alabama Department of Mental Health Substance Abuse Services Administrative Code.

- Rehabilitative Services Professional
- QSAP II
- QSAP III
- Certified Recovery Support Specialist (CRSS)
- QPP
- Licensed Practical Nurse

Billing Unit: A minimum of 4 hours
Maximum Units: 1 per day, 130 days per year

13. **Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. --- (Continued)**

13.d. **Rehabilitative services --- Continued**

Effective 10/01/18

(11) Adult Mental Illness Intensive Day Treatment - An identifiable and distinct program that provides highly structured services designed to bridge acute treatment and less intensive services, such as Rehabilitative Day Program and outpatient services, with the goals of community living skills enhancement, increased level of functioning, and enhanced community integration.
Component Services:

- Individual, group, and family counseling
- Psychoeducational services
- Basic living skills
- Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, and problem solving)
-

Eligible Provider Type:
The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, there must be a program coordinator:

- Rehabilitative Services Professional (all types)

As outlined in Community Mental Health Program Standards Manual, the multi-disciplinary treatment team may also include the following practitioners:

- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- Certified Mental Health Peer Specialist - Adult

Billing Unit: One hour
Maximum Units: 4 per day, 1040 hours per year

(12) Adult Rehabilitative Day Program - An identifiable and distinct program that provides long term recovery services with the goals of improving functioning, facilitating recovery, achieving personal life goals, regaining feelings of self-worth, optimizing illness management, and helping to restore a recipient to productive participation in family and community life.

13. **Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. --- (Continued)**

13.d. **Rehabilitative services --- Continued**

Effective 10/01/18

Component Services:

- Psychoeducational services
- Basic living skills
- Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, and problem solving)
-

Eligible Provider Type:

The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, there must be a program coordinator:

- Qualified Mental Health Provider – Bachelor's

As outlined in Community Mental Health Program Standards Manual, the multi-disciplinary treatment team may also include the following practitioners:

- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- Certified Peer Specialist - Adult

Billing Unit: 15 minutes

Maximum Units: 16 per day, 4160 per year

(13) Child and Adolescent Mental Illness Day Treatment - A combination of goal oriented rehabilitative services designed to improve the ability of a recipient to function as productively as possible in their regular home, school, and community setting when impaired by the effects of a mental health or emotional disorder. Programs that provide an academic curriculum as defined by or registered with the State Department of Education and that students attend in lieu of a local education agency cannot bill Medicaid for the time devoted to academic instruction.

Component Services:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Individual, group and family counseling
- Psychoeducation Services
- Basic living skills
- Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, and problem solving)

13. **Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. --- (Continued)**

13.d. **Rehabilitative services --- Continued**
Effective 10/01/18

Eligible Provider Type:
The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, there must be a program coordinator:

- Rehabilitative Services Professional (all types)

As outlined in Community Mental Health Program Standards Manual, the multi-disciplinary treatment team may also include the following practitioners:

- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- Certified Mental Health Peer Specialist - Youth
- Certified Mental Health Peer Specialist - Parent

Billing Unit: One hour
Maximum Units: 4 per day, 1040 hours per year

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**
Effective Date: 10/01/23

(14) Treatment Plan Review - Review and/or revision of a recipient's individualized mental health and/or substance use disorder treatment plan by a qualified practitioner who is not routinely directly involved in providing services to the recipient. This review will evaluate the recipient's progress toward treatment objectives, the appropriateness of services provided, and the need for continued participation in treatment. This service does not include those activities or costs associated with direct interaction between a recipient and his/her primary therapist regarding the recipient's treatment plan. That interaction shall be billed through an alternative service such as individual counseling.

Eligible Provider Type:

- Physician
- Physician Assistant
- Certified Registered Nurse Practitioner (CRNP)
- Rehabilitative Services Professional
- Service Supervisor
- Senior Social Work Supervisor
- PASS I or PASS II

Billing Unit: 15 minutes
Maximum Units: 1 event with up to 2 units every 6 months, 4 per year

(15) Mental Health Care Coordination – Services to assist an identified Medicaid recipient to receive coordinated mental health services from external agencies, providers or independent practitioners. Key service functions include written or oral interaction in a clinical capacity in order to assist another provider in addressing the specific rehabilitative needs of the recipient, as well as to support continuation of care for the recipient in another setting.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- Licensed Registered Nurse
- Licensed Practical Nurse
- Certified Nursing Assistant
- Certified Medical Assistant
- Qualified Mental Health Provider – Bachelor's
- Social Service Caseworker
- PASS I or PASS II
- CASS-Non-Degreed

Billing Unit: 15 minutes
Maximum Units: 24 per day, 312 per year

13. **Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. --- (Continued)**

13.d. **Rehabilitative services --- Continued**
Effective 10/01/18

(16) Adult In-home intervention - Home based services provided by a treatment team (two-person team) to serve individuals who refuse other outpatient services and/or who need temporary additional support due to increased symptoms or transition from a more intense level of services, to defuse an immediate crisis situation, stabilize the living arrangement, and prevent out of home placement of the recipient.

Component Services:
Key service functions include the following when provided by a team composed of a Rehabilitative Services Professional (master's level clinician) and either a Qualified Mental Health Provider – Bachelor's or a Certified Mental Health Peer Specialist - Adult:

- Individual or family counseling
- Crisis intervention
- Basic Living Skills
- Psychoeducational Services
- Case Management
- Medication Monitoring
- Peer Services (only when team member is a Certified Mental Health Peer Specialist – Adult)

Key service functions include the following when provided by a team composed of a Registered Nurse and a Qualified Mental Health Provider – Bachelor's or a Certified Mental Health Peer Specialist - Adult:

- Crisis Intervention
- Basic Living Skills
- Psychoeducational Services
- Case Management
- Medication Monitoring
- Medication Administration
- Peer Services (only when team member is a Certified Peer Specialist - Adult)

Eligible Provider Type:
In-home intervention for mental illness clients are provided by a two-person team minimally composed of the following:

- Rehabilitative services professional (master's level) or
- licensed registered nurse who must successfully complete an approved case management-training program and either
- a Qualified Mental Health Provider – Bachelor's or
- Certified Mental Health Peer Specialist - Adult

All team members must successfully complete an approved case management-training program.

Billing Unit: 15 minutes
Maximum Units: 24 units per day, 2,016 per year

Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**

Effective Date: 10/01/23

(17) Child and Adolescent In-Home Intervention – Structured, consistent, strength-based therapeutic intervention provided by a team for a child or youth with a serious emotional disturbance (SED) and his or her family for the purpose of treating the child's or youth's behavioral health needs. In-Home Intervention also addresses the family's ability to provide effective support for the child or youth, and enhances the family's capacity to improve the child's or youth's functioning in the home and community. Services are directed towards the identified youth and his or her behavioral health needs and goals as identified in the treatment plan or positive-behavior support plan are developed by a qualified behavioral clinician where appropriate. Services include therapeutic and rehabilitative interventions, including counseling and crisis intervention services, with the individual and family to correct or ameliorate symptoms of mental health conditions and to reduce the likelihood of the need for more intensive or restrictive services. These services are delivered in the family's home or other community setting and promote a family-based focus in order to evaluate the nature of the difficulties, defuse behavioral health crises, intervene to reduce the likelihood of a recurrence, ensure linkage to needed community services and resources, and improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents' or responsible caregivers' skills to care for their child's or youth's mental health conditions. The In-Home Intervention team provides crisis services to children and youth served by the team.

Eligible Provider Type:
In-home intervention for mental illness recipients are provided by a two-person team minimally composed of the following:

- A rehabilitative services professional staff (all types) AND either
  - A Qualified Mental Health Provider – Bachelor's or
  - Certified Mental Health Peer Specialist - Youth

All team members must successfully complete an approved Child and Adolescent In-Home Intervention - training program.

Billing Unit: One day
Maximum Units: One per day, 140 per year

(18) Mental Health and Substance Use Disorders Assessment Update – A structured interview process that functions to evaluate a recipient's present level of functioning and/or presenting needs. The assessment is used to establish additional or modify existing diagnoses, establish new or additional rehabilitation service goals, assess progress toward goals, and/or to determine the need for continued care, transfer, or discharge.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)

13. Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. --- (Continued)

13.d. **Rehabilitative services --- Continued**

Effective 10/01/18

Billing Unit: 15 minutes

Maximum Units: 8 units per day, 32 units per year

(19) Basic Living Skills – Psychosocial services provided to an individual or group to restore skills that enable a recipient to establish and improve community tenure and to increase his or her capacity for age-appropriate independent living. This service also includes training about the nature of illness, symptoms, and the recipient's role in management of the illness.

Eligible Provider Type:

- Rehabilitative Services Professional (all types),
- Licensed Registered nurse,
- Social Service Caseworker,
- Qualified Mental Health Provider – Bachelor's, or
- Qualified Mental Health Provider – Non-Degreed
- QSAP II
- QSAP III
- QPP
- Certified Mental Health Peer Specialist – Adult, Youth, or Parent
- Certified Recovery Support Specialist
- PASS I or PASS II
- CASS – Non-degreed

Billing Unit: 15 minutes

Maximum Units: 2080 units per year
--20 per day (individual)
--8 per day (group)

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. Rehabilitative services ---Continued

Effective Date: 10/01/18

(20) Psychoeducational Services - Structured, topic specific educational services provided to assist the recipient and the families* of recipients in understanding the nature of the identified behavioral health disorder, symptoms, management of the disorder, how to help the recipient be supported in the community and to identify strategies to support restoration of the recipient to his/her best possible level of functioning.

Eligible Provider Type:
- Rehabilitative Services Professional (all types),
- Social Service Caseworker,
- Licensed Registered Nurse
- Qualified Mental Health Provider – Bachelor's, or
- Qualified Mental Health Provider – Non-Degreed
- QSAP II
- QSAP III
- Certified Mental Health Peer Specialist – Adult, Youth, or Parent
- Certified Recovery Support Specialist
- PASS I or PASS II
- CASS – Non-degreed

Billing Unit: 15 minutes
Maximum Units: 416 per year (416 units per year for individual and 416 units per year for group)
8 units (unit = 15 minutes) per day, individual
8 units (unit = 15 minutes) per day, group

(22) Assertive Community Treatment (ACT)/Program for Assertive Community Treatment (PACT) - Treatment services provided primarily in a non-treatment setting by a member of an ACT or PACT team, staffed pursuant to ADMH regulations promulgated in the Alabama Administrative Code for adult recipients with serious mental illness or co-occurring substance use and mental health disorders. Recipients receiving ACT or PACT services are in a high-risk period due to an exacerbation of the behavioral health disorder, and/or are returning from an episode of inpatient/residential psychiatric care, or are consistently resistant to traditional clinic-based treatment interventions and are difficult to engage in an ongoing treatment program.

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. Rehabilitative services ---Continued

Effective Date: 10/01/18

Component Services:

- Intake
- Medical assessment and treatment
- Medication administration
- Medication monitoring
- Individual, group, and/or family counseling
- Crisis intervention
- Mental health care coordination
- Case management
- Psychoeducational Services
- Basic living skills

Eligible Provider Type: The program must be staffed by an assigned team with a minimum of three FTE staff. The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.
Of the three FTE staff, it is required to have a least:

- 1 full-time Rehabilitative Services Professional (master's level clinician)
- 1 full-time Qualified Mental Health Provider – Bachelor's, and
- .50 FTE of either an RN or LPN.

Billing Unit: One day
Maximum Units: 365 days per year

(23) Opioid Use Disorder Treatment – The administration of medication, including the use of FDA approved medications for the use of opioid use disorders, to recipients who have a diagnosed opioid use disorder. Medication is administered to support the recipient's efforts to restore adequate functioning in major life areas that have been debilitated as a result of opioid addiction. This service includes medication administration and concurrent related medical, clinical and case management services.

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. Rehabilitative services ---Continued

Effective Date: 10/01/18

Eligible Provider Type:
ADMH-SA:
The program must be staffed as specified in current and subsequent revisions of:

(1) State regulations established for this service by the Alabama Department of Mental Health and published in the Alabama Administrative Code; and
(2) Federal regulations established for this service by the Substance Abuse and Mental Health Services Administration

Eligible Provider Type for Administration of Medication:

- Physician
- Physician's Assistant
- CRNP
- RN
- LPN

Billing Unit: One day

(24) Peer Support Service (Adult/Child and Adolescent/Family/Recovery Support Specialist) – Peer Support services provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists (Adult, Youth, Family Peer Specialists, Recovery Support Specialist). Peer Support service actively engages and empowers an individual and his/her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual (and family when appropriate) with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to individuals (and family when appropriate) to promote recovery, resiliency and healthy lifestyles and to reduce identifiable behavioral health and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions. Peer supports provide effective techniques that focus on the individual's self-management and decision making about healthy choices, which ultimately extend the members' lifespan. Family peer specialists assist children, youth, and families to participate in the wraparound planning process, access services, and navigate complicated adult/child-serving agencies.
Eligible Provider Type:
DMH – MI: Certified Mental Health Peer Specialist – Youth, Adult, Parent
DMH – SA: Certified Recovery Support Specialist (CRSS)
DMH – DD: Certified Autism Peer Specialist – Child/Youth
Certified Autism Peer Specialist – Family
Component Services (DD Only):

- Mentoring, advocacy, development of coping/problem solving skills
- Promotion of socialization and development of natural supports
- Engagement of community services

Billing Unit: 15 minutes
Maximum Units: Limited to 20 units per day (individual) and 8 units per day (group). 2,080 units per year for group services and 2,080 units per year for individual services.

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. Rehabilitative services ---Continued

Effective Date: 10/01/18

(24) Psychosocial Rehabilitation Services – Working Environment – Psychosocial services that provide rehabilitative supports with the goal of restoring skills needed to be prepared for community-living activities that may result in employability, promote recovery/wellness, prevent the escalation of a mental health condition into a crisis situation or into a chronic/significantly disabling disorder, improve community-based functioning, alleviate symptoms, and decreasing isolation. The goal of the service is to help recipients be prepared for community-living/activities that may ultimately result in employability. This service does not include educational, vocational or job training services.

Eligible Provider Type: The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

- Rehabilitative Services Professional (all types)
- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- Certified Mental Health Peer Specialist – Adult or Youth
- QSAP II
- QSAP III
- QPP (Qualified Paraprofessionals)

Billing Unit: 15 minutes.

Maximum Units: 32 units per day, 320 units per month

(25) Screening – An encounter in which a brief, valid, questionnaire is administered by trained personnel to examine the context, frequency, and amount of alcohol or other drugs used by a recipient. This process seeks to identify recipients who have an alcohol or drug use disorder or are at risk for development of such. The service includes feedback on the screening results, and recommendations and referral for additional services, if indicated. This is a covered service for recipients whose use of alcohol and/or drugs has adversely impacted functioning in a major life area.

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. Rehabilitative services ---Continued

Effective Date: 10/01/18

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- QSAP II
- QSAP III
- QPP, with specialized training

Billing Unit: Episode
Maximum Units: 2 units per year

(26) Brief Intervention – A brief motivational encounter conducted after a recipient has completed an approved alcohol and drug screening procedure in which a potential alcohol or drug use problem was identified. During this brief encounter, a trained clinician provides feedback on the recipient's alcohol and/or drug use patterns, expresses concerns about the pattern of use as clinically indicated, provides advice in regard to strategies to eliminate or cut back in regard to destructive alcohol/drug use patterns, assists in development of an action plan, and initiates referrals as appropriate.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- QSAP II
- QSAP III
- QPP, with specialized training

Billing Unit: 15 minutes
Maximum Units: 8 units per year

Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**

Effective Date: 10/01/2023

(27) Nursing Assessment and Care – Nursing Assessment and Care services are contacts with an individual to monitor, evaluate, assess, establish nursing goals, and/or carry out physicians' orders regarding treatment and rehabilitation of the physical and/or behavioral health conditions of an individual as specified in the individualized recovery plan. It includes providing special nursing assessments to observe, monitor and care for physical, nutritional and psychological issues or crises manifested in the course of the individual's treatment; to assess and monitor individual's response to medication to determine the need to continue medication and/or for a physician referral for a medication review; assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.); venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medication; consultation with the individual's family and/or significant others for the benefit of the client about medical and nutritional issues; to determine biological, psychological, and social factors which impact the individual's physical health and to subsequently promote wellness and healthy behavior and provide medication education and medication self-administration training to the individual and family.

Eligible Provider Type:

- Licensed Registered Nurse
- Licensed Practical Nurse
- Certified Nursing Assistant
- Certified Medical Assistant
- MAC Worker (operating within their scope of practice)

Billing Unit: 15 minutes
Maximum Units: 6 units per day in a specialized level of care; 1,496 units per year

(28) Outpatient Detoxification – Face-to-face interactions with a recipient for the purpose of medically managing mild to moderate withdrawal symptoms from alcohol and/or other drugs in an ambulatory setting. Services are provided in regularly scheduled sessions under a defined set of policies, procedures, and medical protocols by authorized medical personnel.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- QSAP II
- QSAP III
- Certified Recovery Support Specialist (CRSS)
- QPP, with specialized training
- Licensed Registered Nurse
- Licensed Practical Nurse

Other Diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. **Rehabilitative services --- Continued**

Effective Date: 10/01/23

Billing Unit: 1 day;
Maximum Units: 100 days per year

(29) Therapeutic Mentoring* – Therapeutic Mentoring Services provide a structured one on one intervention to a child or youth and their families that is designed to ameliorate behavioral health-related conditions that prevent age-appropriate social functioning. This service includes supporting and preparing the child or youth in age-appropriate behaviors by restoring daily living, social and communication skills that have been adversely impacted by a behavioral health condition. These services must be delivered according to an individualized treatment plan and progress towards meeting the identified goals must be monitored and communicated regularly to the clinician so that the treatment plan can be modified as necessary. Therapeutic mentoring may take place in a variety of settings including the home, or other community settings. The therapeutic mentor does not provide social, educational, recreational or vocational services.

Component Services:

- Basic Living Skills
- Social Skills Training
- Coping Skills Training
- Assessment
- Plan Review
- Progress Reporting
- Transition Planning

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- Social Service Caseworker
- Licensed Registered Nurse
- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- PASS I or PASS II
- CASS – Non-degreed

Billing Unit: 15 minutes
Maximum Units: 416 per year (416 units per year for individual and 416 units per year for group)
8 units (unit = 15 minutes) per day, individual
8 units (unit = 15 minutes) per day, group

(30) Behavioral Health Placement Assessment – A structured face-to-face interview process conducted by a qualified professional for the purpose of identifying a recipient's presenting strengths and needs and establishing a corresponding recommendation for placement in an appropriate level of care. This process may incorporate determination of the appropriateness of admission/commitment to a state psychiatric hospital or a local inpatient psychiatric unit.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- Licensed registered nurse

Billing Unit: 30 minutes
Maximum Units: 4 units/day; 16 units/year

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. Rehabilitative services ---Continued

Effective Date: 10/01/18

The program must be staffed as specified in current and subsequent revisions of regulations established for this service by the Alabama Department of Mental Health Substance Abuse Services Administrative Code.
Billing Unit: 1 day;
Maximum Units: 100 days per year

(29) Therapeutic Mentoring* – Therapeutic Mentoring Services provide a structured one on one intervention to a child or youth and their families that is designed to ameliorate behavioral health-related conditions that prevent age-appropriate social functioning. This service includes supporting and preparing the child or youth in age-appropriate behaviors by restoring daily living, social and communication skills that have been adversely impacted by a behavioral health condition. These services must be delivered according to an individualized treatment plan and progress towards meeting the identified goals must be monitored and communicated regularly to the clinician so that the treatment plan can be modified as necessary. Therapeutic mentoring may take place in a variety of settings including the home, school or other community settings. The therapeutic mentor does not provide social, educational, recreational or vocational services.

Component Services:

- Basic Living Skills
- Social Skills Training
- Coping Skills Training
- Assessment
- Plan Review
- Progress Reporting
- Transition Planning

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- Social Service Caseworker
- Licensed Registered Nurse
- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- PASS I or PASS II
- CASS – Non-degreed

Billing Unit: 15 minutes
Maximum Units: 416 per year (416 units per year for individual and 416 units per year for group)
8 units (unit = 15 minutes) per day, individual
8 units (unit = 15 minutes) per day, group

(30) Behavioral Health Placement Assessment – A structured face-to-face interview process conducted by a qualified professional for the purpose of identifying a recipient's presenting strengths and needs and establishing a corresponding recommendation for placement in an appropriate level of care. This process may incorporate determination of the appropriateness of admission/commitment to a state psychiatric hospital or a local inpatient psychiatric unit.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- Licensed registered nurse

Billing Unit: 30 minutes
Maximum Units: 4 units/day; 16 units/year

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. Rehabilitative services ---Continued

Effective Date: 10/01/18

(31) Behavioral Support – positive behavior support therapy and monitoring is designed to address challenging behaviors in the home and community for children and youth with ASD or ASD with co-occurring IDD. A behavioral therapist writes and monitors a behavioral management plan that includes specific behavioral objectives and interventions that are designed to diminish, extinguish, or improve specific behaviors related to the child's or youth's behavioral health condition. The behavioral therapist supervises and coordinates the interventions and trains others who works with the family to implement the plan in the home and in the community.

Component Services:

- Discrete Trial Training- PASS I, PASS II, CASS
- Incidental Teaching- PASS I, PASS II, CASS
- Pivotal Response Training- PASS I, PASS II, CASS
- Verbal Behavior Intervention- PASS I, PASS II, CASS
- Functional Communication Training- PASS I, PASS II, CASS
- Coping Skills Training- PASS I, PASS II, CASS
- Assessment- PASS I, PASS II
- Reduction of Environmental Barriers to Learning- PASS I, PASS II, CASS
- Maladaptive Behavior Reduction- PASS I, PASS II, CASS
- Functional Behavior Assessment- PASS I, PASS II
- Functional Analysis- PASS I
- Crisis Intervention- PASS I, PASS II
- Social Skills Therapy- PASS I, PASS II, CASS
- Basic Living Skills- PASS I, PASS II, CASS
- Psycho-educational Services- PASS I, PASS II, CASS
- Sensory Integration- PASS I, PASS II, CASS
- Development of Individual Program Plan- PASS I
- Progress Reporting- PASS I
- Treatment Plan Review- PASS I
- Transition Planning- PASS I
- Family Training- PASS I, PASS II, CASS
- Augmentative Communication Training- PASS I, PASS II, CASS

Eligible Provider Type:

- PASS I or PASS II
- CASS – Non-degreed

Billing Units: 15 minutes
Maximum Units: 16 units/day; 4,160 units/year (1040 hours annually)

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. Rehabilitative services ---Continued

Effective Date: 10/01/18

(32) In-Home Therapy – A structured, consistent, strength-based therapeutic relationship between a licensed clinician and a child or youth with ASD or ASD and co-occurring IDD and his or her family for the purpose of treating the child's or youth's behavioral health needs. In-Home Therapy services are provided under a multidisciplinary team model. In-home therapy also addresses the family's ability to provide effective support for the child or youth and enhances the family's capacity to improve the child's or youth's functioning in the home and community.

Component Services:

- Psychoeducational Services- PASS I, PASS II
- Individual counseling/therapy- PASS I, PASS II
- Family counseling/therapy- PASS I, PASS II
- Group counseling/therapy- PASS I, PASS II
- Coping Skills Training (has further description in text of other services)- PASS I, PASS II
- Assessment- PASS I
- Therapeutic Treatment- PASS I, PASS II
- Crisis Intervention- PASS I, PASS II
- Basic Living Skills- PASS I, PASS II
- Social Skills Therapy- PASS I, PASS II
- In-Home Intervention- PASS I, PASS II
- Treatment Plan Review- PASS I
- Progress Reporting- PASS I
- Development of Individual Program Plan- PASS I
- Transition Planning- PASS I

Eligible Provider Type:

- PASS I or PASS II

Billing Unit: 15 minutes
Maximum Units: 8 units/day; 832 units/year (208 hours annually) 4hrs/wk

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)
13.d. Rehabilitative services ---Continued

Effective 10/01/222

(33) Intensive Family Intervention by a Multi-Person Team

This service is intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification, or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, psychiatric residential treatment facilities, or residential treatment services) for the identified youth. Services are delivered by a multi-person team staffed as defined below and are provided primarily to youth in their living arrangement and within the family system. Services are designed to address both the mental health needs of the youth and the interactions among family members that contribute to an unstable living environment as identified in the Individualized Treatment Plan. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgement, the beneficiary is not present during the delivery of the service, but remains the focus of the service. Any medical or remedial services (provided in a facility, home, or other setting) be recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

The clinical admission criteria include the following:

1. A mental illness diagnosis and/or a substance abuse diagnosis and related substantial functional impairment which significantly interferes with the child's role or functioning in the family, school, or community such that traditional outpatient services are not sufficient to meet the need.
2. The youth and/or family has one or more of the following characteristics:

- Insufficient or severely limited resources or skills necessary to cope with the youth's behavioral health crisis
- Are involved in or at serious risk of involvement with the court system
- Have anti-social, aggressive/violent, substance abusing behaviors
- Are at risk of out-of-home placement and require intensive, coordinated clinical and supportive intervention
- Are returning from out-of-home placement where the above behaviors received treatment

The service array, frequency, and duration must conform to the respective team model and include resource coordination/acquisition to achieve the youth's and their family's goals and aspirations of self-sufficiency, resiliency, permanency, and community integration. A variety of services are provided by team members and include the following:

Intake

Individual Counseling

Family Counseling

Medication Monitoring

Crisis Intervention

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)

13.d. Rehabilitative services ---Continued

Psychoeducation

Therapeutic Mentoring

Mental Health Care Coordination

Basic Living Skills

Eligible Provider Type:

The Intensive Family Intervention team is staffed and functions consistent with the evidence-based criteria of a nationally recognized Intensive Family Intervention models such as Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), or Multi-Dimensional Family Therapy (MDFT) or other model approved by the respective state agency. The specific model of Intensive Family Intervention must be approved by the respective state agency. The team must be approved by the respective credentialing oversight body as having the staff, training, operation, and quality assurance measures required by the model.

At a minimum the team will have a supervisor who has a Master's Degree in psychology, social work, counseling, or other human service field and who has two years post-Master's supervised experience in child and adolescent services and other team members who possess a Master's Degree in psychology, counseling, social work, or other human service field and who have either completed a clinical practicum or have six months post-graduate clinical experience, and who have received or will receive two years of post-graduate supervised experience. The Master's level staff may provide Intake, Individual Counseling, Family Counseling, Medication Monitoring, Crisis Intervention, Psychoeducation, Therapeutic Mentoring, Mental Health Care Coordination, and Basic Living Skills. Depending on local circumstances, the team may include a person with a bachelor's degree in a human service field. The Bachelor's level team member may provide Basic Living Skills, Crisis Intervention, Therapeutic Mentoring, Psychoeducation, and Mental Health Care Coordination.

Billing Unit: One day
Maximum Units: 180 per year

Youth and Adult Community-Based Mobile Crisis Response and Stabilization Services

Community-Based Youth (under the age of 21) and Adults (age 21 or older) Mobile Crisis Response and Stabilization:
Mobile Crisis Teams (MCT) are designed to specifically diffuse and mitigate a behavioral health crisis. MCT services offer community-based interventions to youth and adults and their families experiencing a behavioral health crisis-whether in their homes, schools, or communities. The MCT provides crisis stabilization services to adults, children, and their families/caregivers, experiencing a behavioral health crisis. The MCT may be delivered in-person, in-home, and/or in community settings, and is available within a timely manner. Telemedicine and telephonic support may be provided until an in-person response arrives and or as follow-up post-crisis regarding coordination and referrals.

Services to be provided *may* include:

- Intake Evaluation
- Crisis Intervention
- Behavioral Health Placement Assessment
- Psychoeducational Services
- Individual Counseling
- Family Counseling
- Mental Health Care Coordination
- Peer Support Services
- Mental & Substance Use Disorders Assessment

Response from MCTs is typically in teams of two; however, this may differ if the team is dispatched from a staffed facility or if, as in rural communities, **telemedicine** services are utilized. The two-person team is available **24 hours a day, 7 days per week** and can travel throughout the state to respond on location. The stabilization service supports the child and or adult's ability to manage daily activities and establishes clear connections to treatment services and community supports to reduce the likelihood of ongoing behavioral health crises. Services may also include follow-up interventions for a period of up to **72 hours** after the initial response that may include, where appropriate, additional MCT and/or behavioral health crisis intervention services, de-escalation, and coordination with and referrals to health, social, emergency management, and other services and supports as needed to effect symptom reduction and harm reduction. If continued stabilization services are identified after **72 hours**, a stabilization plan must be developed for coordination with referrals for continued stabilization services.

The MCT ("Team") Composition must include a team of at least two of the following licensed and/or credentialed clinician in a supervisory role who has expertise and experience using evidence-based assessment tools with target populations:

- Rehabilitative Service Professional (Masters Level and Above)
- Qualified Mental Health Provider (Bachelors Level)
- Mental Health Certified Youth Peer
- Mental Health Certified Parent Peer
- Certified Recovery Support Specialist

In order to claim enhanced Federal Medical Assistance Percentage (eFMAP) for services using the 'community-based mobile crisis intervention services' model, the requirements described in section 1947(b) of the Act must be met, including providing services to persons outside of a hospital or other facility setting, through a multidisciplinary team, trained in trauma-informed care, de-escalation strategies, and harm reduction.

The team must include, at a minimum, at least one individual who may conduct an assessment within their authorized scope of practice under state law and other professionals or paraprofessionals with appropriate expertise in behavioral health care.

Location: Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Limitation of Services

14. Services for Individuals age 65 or older in institutions for mental diseases.

Effective Date: 02/01/17

14.a. Inpatient psychiatric services: for recipients age 65 or older are unlimited if medically necessary and the admission and/or the continued stay reviews meet the approved psychiatric criteria.

In order to participate in the Title XIX Medicaid program and to receive Medicaid payment for inpatient services for individuals 65 or older, a provider must meet the following requirements:

(1) Be certified for participation in the Medicare/Medicaid program;

(2) Be licensed as a free-standing acute care geriatric, psychiatric hospital in accordance with current rules contained in the Alabama Administrative Code Chapter 420-5-7. State hospitals that do not require licensing as per state law are exempt from this provision (Alabama Code, Section 22-50-1, et.seq.);

(3) Be accredited by the Joint Commission on Accreditation of Healthcare Organizations;

(4) Specialize in the care and treatment of geriatric patients with serious mental illness;

(5) Have on staff at least one full time board certified geriatric psychiatrist/geriatrician; or a full-time board certified adult psychiatrist with a minimum of 3 years experience caring for geriatric patients 65 or older.

(6) Employ only staff who meet training/ certification standards in the area of adult psychiatry as defined by the State's Mental Health Authority;

(7) Be recognized as a teaching hospital, and affiliated with at least one four-year institution of higher education with a multi-disciplinary approach to the care and treatment of geriatric patients with serious mental illness;

(8) Provide out-patient and community liaison services throughout the State of Alabama directly or through contract with qualified providers;

(9) Be in compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act;

(10) Execute an Alabama Medicaid Provider Agreement for participation in the Medicaid program;

(11) Submit a written description of an acceptable utilization review plan currently in effect;

(12) Submit a budget of cost for medical inpatient services for its initial cost reporting period, and

(13) Be under the jurisdiction of the State's mental health authority.

State/Territory Alabama
AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided [ ] No limitations
[X] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

[ ]Provided [ ] No limitations

[X] Provided in accordance with section 2302 of the Affordable Care Act

[X]With limitations* [ ] Not Provided:

*Description provided on attachment

Limitation of Services

14. **Services for individuals age 65 or older in institutions for mental diseases.**

Effective Date: 04/01/91

14. b. **Nursing Facility Services: for individuals age 65 or older in institutions for mental diseases must be prior authorized. Prior authorization is based on medical necessity.**

(1) All nursing services to meet the total needs of the patient including treatment and administration of medications ordered by the physician.

(2) Personal services and supplies for the comfort and cleanliness of the patient. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the patient to maintain a clean, well-kept personal appearance.

(3) Room (semiprivate or ward accommodations) and board, including special diets and tubal feedings necessary to provide proper nutrition. This includes feeding patients unable to feed themselves.

(4) All services and supplies for incontinent patients.

(5) Bed and bath linens, including linen savers such as cellupads, and diapers.

(6) Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, sterile and non-sterile dressings, special dressings (such as ABD pads and pressure dressings) intravenous administration sets, normal intravenous fluids (such as glucose, D5W, D10W).

(7) Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, and other items generally provided by nursing homes for the general use of all patients.

(8) Sterile and non-sterile dressings and medications for prevention and treatment of bed sores.

Limitation of Services

14. **Services for individuals age 65 or older in institutions for mental diseases.**

14. b. **Nursing Facility Services -- (Continued)**

Effective Date: 10/01/93

(9) Medically necessary Over-the-Counter (non-legend) drug products prescribed or ordered by a physician.

(10) Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, sterile and non-sterile dressings, special dressings (such as ABD pads and pressure dressings) intravenous administration sets, normal intravenous fluids (such as glucose, D5W, D10W).

(11) Personal apparel laundry services.

Limitation of Services

15. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Effective Date: 04/01/91

A. **Services in a public institution for the mentally retarded or persons with related conditions. Must be prior authorized by Alabama Medicaid Agency or the Department of Mental Health as applicable.**

B. **Community mental retardation units providing 24-hour personal care to at least four but no more than 15 mentally retarded persons or persons with related conditions. Must be prior authorized by the Department of Mental Health.**

1. Services included in basic (covered) nursing facility charges.

2. All nursing services to meet the total needs of the patient including treatment and administration of medications ordered by the physician.

3. Personal services and supplies for the comfort and cleanliness of the patient. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the patient to maintain a clean, well-kept personal appearance.

4. Room (semiprivate or ward accommodations) and board, including special diets. This includes feeding patients unable to feed themselves.

5. All services and supplies for incontinent patients.

6. Bed and bath linens, including linen savers such as cellupads, and diapers.

7. Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, sterile and non-sterile dressings, special dressings (such as ABD pads and pressure dressings) intravenous administration sets, normal intravenous fluids (such as glucose, D5W, D10W).

Limitation of Services

15. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care. -- Continued

15. B. **Community mental retardation units providing 24-hour personal care to at least four but no more than 15 mentally retarded persons or persons with related conditions. Must be prior authorized by the Department of Mental Health. -- Continued**

8. Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, and other items generally provided by nursing facilities for the general use of all patients.

9. Sterile and non-sterile dressings and medications for prevention and treatment of bed sores.

10. Medically necessary Over-the-Counter (non-legend) drug products prescribed or ordered by a physician.

11. Personal apparel laundry services.

Limitations of Services

16. **Inpatient psychiatric facility services for individuals under 21 years of age.**

Effective Date: 01/01/02
Inpatient psychiatric facility services for individuals under 21 years of age are unlimited if medically necessary and the admission and continued stay reviews meet the approved psychiatric criteria. These days do not count against the inpatient benefit limitations for acute care hospitals. Services may be provided in a hospital or in a psychiatric residential treatment facility that meets the requirements in 42 CFR, Part 441, Subpart D, and Part 483, Subpart G. Detailed information regarding covered services and provider eligibility appears in Chapter 41 of the Alabama Medicaid Agency Administrative Code. Services are limited to recipients under 21 years of age, or if the recipient was receiving services immediately before he reached age 21, to the earlier of the date the recipient no longer requires the services, the date he reaches age 22, or the expiration of covered days.

Limitation of Services

17. **Nurse-midwives Services**

Effective Date: 10/01/93
Providers in this program are limited to persons who are licensed as Registered Nurses and who are also licensed as "Certified Nurse Midwife."

Services provided may not exceed those for which a nurse midwife is authorized to provide under state law and regulations.

Detailed information regarding covered services and provider eligibility appears in Chapter 21 of the Alabama Medicaid Agency Administrative Code.

Limitation of Services

18. **Hospice Care (In accordance with section 1905(o) of the Act.)**

Effective Date: 09/09/98

Medicaid will utilize the most recent benefit periods established by the Medicare Program.

Effective Date: 10/01/90

Hospice care is available under Medicaid for eligible recipients certified as being terminally ill with a medical prognosis that his or her life expectancy is six months or less. Hospice care services within the Alabama Medicaid Program are governed by §1905(o) of the Social Security Act, 42 C.F.R. Part 418 and the Alabama Medicaid Agency Administrative Code. Services must be provided by a Medicare certified hospice program.

The individual must voluntarily elect hospice and file an election statement with a Medicaid participating hospice provider.

Hospice Care is provided independent of standard Medicaid benefits. Eligible individuals electing hospice care waive all rights to services covered under the Medicaid program that are also covered under the Medicare Program related to the treatment of the terminal illness or related condition for which hospice care was elected.

Hospice coverage is available for unlimited days, subdivided into four election periods as follows: two periods of ninety (90) days each, a subsequent period of thirty (30) days, and a subsequent extension period during the individual's lifetime. A recipient may revoke the election of hospice care at any time during an election period. The recipient forfeits coverage for any remaining days in that election period. Medicaid coverage of benefits waived during the election period will be resumed.

A Medicaid beneficiary who resides in a nursing facility may elect hospice services. The hospice must have a contract with each nursing facility to clarify responsibilities.

The following services are covered hospice services subject to limitations in accordance with 42 C.F.R. -418.200 and §1905(o) of the Social Security Act:

(1) Nursing care
(2) Medical social services
(3) Physicians services
(4) Counseling services
(5) Short-term inpatient care

Limitation of Services

18. **Hospice Care - (In accordance with section 1905(o) of the Act.)**
--- Continued

(6) Medical appliances and supplies, including drugs and biologicals
(7) Home health aide services and homemaker services
(8) Physical therapy, occupational therapy, and speech-language pathology services
(9) Nursing facility room and board

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Effective Date: 07/01/88

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

/X / Provided: /X / With limitations*
**

/ _ / Not provided.

20. Extended services to pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

\+ ++

/ X/ Provided: /X / Additional coverage /X / With limitations*

b. Services for any other medical conditions that may complicate pregnancy.

\+ ++

/ X/ Provided: /__/ Additional coverage /X / With limitations*

/ _ / Not provided.

Effective Date: 10/01/91

c. Preventive Health Education services to include prenatal/ postnatal parenting education.

/ X/ Provided: / _ / No Limitations / X/ With limitations*

/ _ / Not provided.

+Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.
++Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.
**Additional medically necessary services beyond limitations are covered for children under 21 years of age referred through the E.P.S.D.T. Program.
*Description provided on attachment.

Limitation of Services

19. **Case Management Services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).**

Effective Date: 07/01/88

1. Target Group 1 - Mentally Ill

   a. Services will be limited to chronically mentally ill (CMI) adults, seriously emotionally disturbed (SED) children and adolescents.

   b. Services shall be limited to 52 hours per client per calendar year.

2. Target Group 2 - Mentally Retarded

   a. Services shall be limited to individuals with a diagnosis of mental retardation 21 years of age or older or 18 years of age or older if the individual has received 12 years of education as documented by a statement or certificate from the appropriate local education agency or the State Department of Education.

   b. Services shall be limited to a maximum of 52 hours per client per calendar year.

Limitation of Services

20. **Extended services to pregnant women.**

Effective Date: 07/01/91

a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends are limited to Medicaid covered services that are certified as medically necessary by a physician.

Effective Date: 07/01/91

Additional inpatient days for deliveries may be authorized upon request for recipients who have exhausted their initial covered benefit days. Approval is limited to medically necessary days for deliveries (onset of active labor through discharge up to a maximum of eight days).

b. Services for any other medical conditions that may complicate pregnancy are limited to Medicaid covered services that are certified as medically necessary by a physician.

Effective Date: 10/01/94

c. Prenatal Education Services.

Prenatal Education services performed only by a qualified provider to eligible pregnant women, consisting of no more than 12 visits during a two-year period beginning with the first date of service. Qualified providers are physicians or other licensed practitioners of the healing arts practicing within the scope of their practice as defined by state law, or by specially trained individuals working under the personal supervision of an individual licensed under state law to practice medicine or osteopathy or if the service is one provided by a facility under the direction of a physician.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Effective Date: 01/01/92

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible# provider (in accordance with section 1920 of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

/ X/ Not provided.

Effective Date: 01/01/92

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/X / Provided: /_/ No limitations /X / With limitations*

/_/ Not provided.

Effective Date: 01/01/92

23. #Certified Pediatric or family nurse practitioners' services.

/ X/ Provided: /_/ No limitations /X / With limitations*
**

#VIA HCFA-PITN-MCD-4-92

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

** Additional medically necessary services beyond limitations are covered for children under 21 years of age referred through the E.P.S.D.T. Program.

* Description provided on attachment.

22. **Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).**

Effective Date: 01/01/92
Respiratory care services are provided only for children under 21 years of age referred through the EPSDT Program.

23. 1905(a)(21): **Certified Pediatric or family nurse practitioners' services.**

Effective Date: 07/01/19
Nurse-Practitioners Services - Providers in this program are limited to Registered Nurses who are also certified as a family nurse-practitioner, or pediatric nurse practitioner.

A nurse practitioner who is employed and reimbursed by a facility that receives reimbursement from Alabama Medicaid Program for services provided by the nurse practitioner shall not bill separately if these services are included in the reimbursement made to that facility through their cost report. (i.e., hospitals, FQHCs, rural health clinics, etc.)

Services provided may not exceed those for which a nurse practitioner is authorized to provide under State regulations.

Office visits provided by a nurse practitioner are counted in the recipient's physician's visit limitation as described in Attachment 3.1-A.

Work must be supervised by or associated with a physician.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: /_/ No limitations /X/ With limitations*
/_/ Not provided. **

b. Services of Christian Science nurses.

/X/ Provided: /_/ No limitations /X/ With limitations*
/_/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/X/ Provided: /_/ No limitations /X/ With limitations*
/_/ Not provided.

d. Nursing facility services for patients under 21 years of age.

/X/ Provided: /_/ No limitations /X/ With limitations*
/_/ Not provided. **

e. Emergency hospital services.

/_/ Provided: /_/ No limitations /_/ With limitations*
/X/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/X/ Provided: /_/ No limitations /X/ With limitations*
/_/ Not provided.

**Additional medically necessary services beyond limitations are covered for children under 21 years of age referred through the E.P.S.D.T. Program.

*Description provided on attachment.

Limitation of Services

24. **Any Other Medical Care and any other type Remedial Care Recognized under State law, specified by the Secretary.**

Effective Date: 02/01/2009

24.a. Transportation

(1) Emergency ambulance services are provided eligible recipients between:

(a) Scene (address) of emergency to hospital.
(b) Nursing facility to hospital.
(c) Local hospital to specialized hospital. (Example: From Montgomery to University Hospital in Birmingham.)

(2) Medically necessary non-emergency ambulance service is provided to eligible recipients who must be bed-confined or have debilitating physical condition(s) that require travel by stretcher only and require ground transportation to receive medical services.

(3) Non-emergency ambulance services provided eligible recipients outside of local area over 100 miles one way, must be prior authorized by the Alabama Medicaid Agency,

(4) Certification that medical condition warrants the use of ambulance service is required by the attending physician or facility nurse for both emergency and non-emergency use.

Limitation of Services

24. **Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)**

24.b. **Services of Christian Science nurses** are provided only for children under 21 referred through the EPSDT Program.

24.c. **Services provided in Christian Science sanitoria** are provided only for children under 21 referred through the EPSDT Program.

Effective Date: 04/01/91

24.d. **Nursing Facility Services for Patients Under 21 Years of Age**

(1) Must be prior authorized by the Alabama Medicaid Agency;

(2) Services are limited to items of care specified by agreement between the Alabama Medicaid Agency and the nursing facility.

Effective Date: 04/01/91

Services included in basic (covered) nursing facility charges.

(a) All nursing services to meet the total needs of the patient including treatment and administration of medications ordered by the physician.

(b) Personal services and supplies for the comfort and cleanliness of the patient. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the patient to maintain a clean, well-kept personal appearance.

(c) Room (semiprivate or ward accommodations) and board, including special diets and tubal feedings necessary to provide proper nutrition. This includes feeding patients unable to feed themselves.

(d) All services and supplies for incontinent patients.

(e) Bed and bath linens, including linen savers such as cellu pads, and diapers.

Limitation of Services

24. **Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)**

24.d. **Nursing Facility Services for Patients Under 21 Years of Age. (Continued)**

24.d (2) (f) Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, sterile and non-sterile dressings, special dressings (such as ABD pads and pressure dressings) intravenous administration sets, normal intravenous fluids (such as glucose, D5W, D10W).

(g) Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, and other items generally provided by nursing homes for the general use of all patients.

(h) Sterile and non-sterile dressings and medications for prevention and treatment of bed sores.

(i) Medically necessary Over-the-Counter (non-legend) drug products prescribed or ordered by a physician.

(j) Personal apparel laundry services.

24.f. **Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.**

Effective Date: 01/01/92
Personal Care Services are provided only for children under 21 referred through the EPSDT Program.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Effective Date: 01/01/92

g. Ambulatory Surgical Center Services

/ X/ Provided: /_/ No limitations / X/ With limitations*
/_/ Not provided. **

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided __X__ not provided

Effective date: 01/01/95

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or in another location.

X	Provided:	____	State Approved (Not Physician) Service Plan Allowed
		____	Services Outside the Home Also Allowed
		X	Limitations Described on Attachment*
__	Not Provided		

**Additional medically necessary services beyond limitations are covered for children under 21 years of age referred through the E.P.S.D.T. Program.

*Description provided on attachment.

Limitation of Services

24. **Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued).**

Effective Date: 01/01/92

24.g. **Ambulatory Surgical Center Services**

Services are limited to three ambulatory surgical center visits per calendar year provided to patients not requiring hospitalization.

Limitation of Services

Effective Date: 01/01/95

26. Personal Care Services that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or in another location and are provided only for children under 21 years of age referred through the EPSDT Program.

State of Alabama
Self-Directed Personal Assistance Services State Plan Amendment

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1915(j)

X Self-Directed Personal Assistance Services**,** as described and limited in Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

State of Alabama
Self-Directed Personal Assistance Services State Plan Amendment

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

X Self-Directed Personal Assistance Services, as described in Supplement 2 to Attachment 3.1-A.

X Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

_____ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

PRA Disclosure Statement *The purpose of the PRA package is to provide a mechanism for states who voluntarily elect to provide medical assistance under Section 1934(a)(1) with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. 42 CFR 460.2 implements sections 1895, 1905(a), and 1934 of the Act, which authorizes the establishment of PACE as a State option under Medicaid to provide for Medicaid payment to, and coverage of benefits under, PACE. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1027 (Expires: 06/30/2023). The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

State of Alabama
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(26) and 1934

X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

State of Alabama
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)
1905(a)(26) and 1934

__X__ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

State of Alabama
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

Coverage Template for Freestanding Birth Center Services

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

☐ Provided ☐ No limitations ☐ With limitations X None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

☐ Provided ☐ No limitations ☐ With limitations (please describe below)

X Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

☐ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

__ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

__ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

State/Territory: Alabama
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S)

29. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: X

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may notconduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: _Alabama__

TARGETED CASE MANAGEMENT SERVICES
Targeted Group 1 Mentally Ill Adults

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Mentally Ill Adults
The population to be served consists of functionally limited individuals 18 years of age or older with multiple needs who have been assessed by a qualified professional and have been found to require mental health case management. Such persons have a diagnosis included in the ICD-10 as appropriate to date of service (other than developmental/intellectual disabilities, autism spectrum disorder, organic mental disorder, traumatic brain injury, or substance abuse), impaired role functioning, and a documented lack of capacity for independently accessing, and sustaining involvement with needed services.

Medicaid recipients may receive TCM services in more than one target group, or case management services from another program if the Agency determines this would not present a duplication of services.

_**X**_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_**X**_ Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_**X**_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
    - taking the individual's history;

State Plan under Title XIX of the Social Security Act
State/Territory: _Alabama__

TARGETED CASE MANAGEMENT SERVICES
Targeted Group 1 Mentally Ill Adults

- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - o services are being furnished in accordance with the individual's care plan;
    - o services in the care plan are adequate; and

State Plan under Title XIX of the Social Security Act
State/Territory: _Alabama__

TARGETED CASE MANAGEMENT SERVICES
Targeted Group 1 Mentally Ill Adults

- changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

____Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Target Group 1: Mentally Ill Adults

The case management provider will be either Regional Boards incorporated under Act 3l0 of the l967 Alabama Act who have demonstrated ability to provide targeted case management services directly, or the Alabama Department of Mental Health (AMDH). Providers. Providers must be certified by the Alabama Department of Mental Health and provide services through a contract with ADMH. Act 310 provides for the formation of public corporation to contract with the Alabama
Department of Mental Health in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

Individual case managers must meet the following qualifications:

(A) At a minimum, a Bachelor of Arts or a Bachelor of Science degree preferably in a human services related field, or

(B) A registered nurse, and

(C) Training in a case management curriculum provided or approved by the Department of Mental Health and the Alabama Medicaid Agency.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 1 Mentally Ill Adults

2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
__**X**___Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 1 Mentally Ill Adults

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 2 Intellectually Disabled Adults

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Intellectually Disabled Adults

The population to be served consists of individuals 18 years of age or older with a diagnosis of mental retardation, as defined by the American Association of Mental Retardation (formerly AAMD).

The individual's diagnosis must be determined by a Qualified Mental Retardation Professional (QMRP) and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to an intellectual disability. Such persons may have other or secondary disabling conditions.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, ICFs/MR, ICFs/MR 15 bed or less, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

_**X**_ Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_**X**_ Entire State
__ _ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
__ _ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_**X**_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 2 Intellectually Disabled Adults

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:

    - taking client history;
    - identifying the individual's needs and completing related documentation; and
    - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
    - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
    - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
    - identifies a course of action to respond to the assessed needs of the eligible individual;

- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
    - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 2 Intellectually Disabled Adults

and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

___Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Target Group 2: Intellectually Disabled Adults

The Alabama Department of Mental Health (ADMH) case management provider will be Regional Boards incorporated under Act 3l0 of the l967 Alabama Acts who have demonstrated ability to provide targeted case management services directly, by ADMH employees, or other contractors of ADMH. Act 310 provides for the formation of public corporation to contract with the Alabama Department of Mental Health in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness, mental retardation, and substance abuse populations.

Individual case managers must meet the following qualifications:

(A) At a minimum, a Bachelor of Arts or a Bachelor of Science degree, or
(B) A registered nurse, and
(C) Training in a case management curriculum provided or approved by the Department of Mental Health and the Alabama Medicaid Agency.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 2 Intellectually Disabled Adults

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
_**X**__ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 2 Intellectually Disabled Adults

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other

services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 3 Disabled Children

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Disabled Children
The population to be served consists of individuals age 0-20 or until the individual reaches age 21 considered to be disabled as defined in the following six subgroups:

(A) Intellectually Disabled/related conditions: (Individuals in this subgroup will be age 0-17.)

(1) Intellectually Disabled - diagnosis must be determined and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to mental retardation.

(2) Related conditions - individuals who have a severe chronic disability that meets all of the following conditions:

(a) It is attributable to:

(i) Cerebral palsy or epilepsy; or

(ii) Any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(i) Self-care,

(ii) Understanding and use of language,

(iii) Learning,

(iv) Mobility,

(v) Self-direction,

(vi) Capacity for independent living.

(B) Seriously emotionally disturbed:

I. In order to meet the definition of seriously emotionally disturbed, the recipient must meet the following criteria for (I & II) *or* (I & III): Diagnosis:

a. Must have a DSM/ICD diagnosis. A primary diagnosis of a "Z" code, substance use, autism spectrum disorder, developmental/intellectual disability, organic mental disorder, or traumatic brain injury does not meet the criteria.

II. Jeopardy of being Separated from Family (Out-of-Home Placement):

a. Still residing in the community but in jeopardy of being separated from family as the result of a serious emotional disturbance.

III. Functional Impairments/Symptoms/Risk of Separation – Must have a. **or** b. **or** c. as the result of a serious emotional disturbance:

a. Functional Impairment – Must have substantial impairment in one of the following capacities to function (corresponding to expected developmental level):

i. Autonomous Functioning: Performance of the age appropriate activities of daily living, e.g., personal hygiene, grooming, mobility;

ii. Functioning in the community – e.g., relationships with neighbors, involvement in recreational activities;

iii. Functioning in the Family or Family Equivalent – e.g., relationships with parents/parent surrogates, siblings, relatives;

iv. Functioning in School/work – e.g., relationships with peers/teachers/co-workers, adequate completion of school work.

b. Symptoms – Must have one of the following:

i. Features associated with Psychotic Disorders

ii. Suicidal or Homicidal Gesture or Ideation

c. Risk of Separation:

Without treatment, there is imminent risk of separation from the family/family equivalent or placement in a more restrictive treatment setting.

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(b) Has experienced structured, supportive residential treatment, other than hospitalization, for a total of at least two months in their lifetime;
(c) Has been assigned to a program of psychotropic medication; or
(d) Has received mental health outpatient care for a period of at least six (6) months, or for more than twenty (20) sessions, or has been admitted for treatment on two or more occasions.

(2) Indicators of Mental Health Treatment Needs:

(a) Family history of alcohol or drug abuse,
(b) Family history of mental health treatment,
(c) Failure to thrive in infancy or early development indicated in medical records,
(d) Victim of child abuse, neglect or sexual abuse,
(e) Pervasive or extreme acts of aggression against self, others, or property (homicidal or suicidal gestures, fire setting, vandalism, theft, etc.), or
(f) Runaway episode(s) of at least twenty-four (24) hours duration.

(3) Current Functioning - problem areas of one year duration or substantial risk of over one year duration.

(a) Is not attending school (and has not graduated), is enrolled in a special education curriculum, or has poor grades;
(b) Dysfunctional relationship with family and/or peers;
(c) Requires help in basic, age-appropriate living skills;
(d) Exhibits inappropriate social behavior; or
(e) Experiences serious discomfort from anxiety, depression, irrational fears, and concerns (indicated by serious eating or sleeping disorders, extreme sadness, social isolation, etc.).

(C) Sensory impaired:

(1) Blind - One who after the best possible correction has no usable vision; therefore, must rely upon tactile and auditory senses to obtain information.

(2) Partially sighted - One who has a visual acuity of 20/70 or less in the better eye with the best possible correction, has a peripheral field so restricted that it affects the child's ability to learn, or has

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a progressive loss of vision which may in the future affect the child's ability to learn.

(3) Deaf - A hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification which adversely affects educational performance.

(4) Blind multi-need - One who has a visual impairment (as defined in (C)(l) and (C)(2) above) and a concomitant disabling condition.

(5) Deaf multi-need - One who has a hearing impairment (as defined in (C)(3) above) and a concomitant disabling condition.

(6) Deaf-blind - One who has concomitant hearing and visual impairments, the combination of sensory impairments causing such severe communication and other developmental and educational problems that they cannot be properly accommodated in the educational programs by the Alabama School for the Blind or the Alabama School for the Deaf.

(D) Disabling health condition(s) - One which is severe, chronic and physical in nature, requiring extensive medical and habilitative/rehabilitative services:

(1) Central nervous system dysraphic states, (such as spina bifida, hydranencephaly, encephalocele);

(2) Cranio-facial anomalies, (such as cleft lip and palate, Apert's syndrome, Crouzon's syndrome);

(3) Pulmonary conditions, (such as cystic fibrosis);

(4) Neuro-muscular conditions, (such as cerebral palsy, arthrogryposis, juvenile rheumatoid arthritis);

(5) Seizure disorders, (such as those poorly responsive to anticonvulsant therapy and those of mixed seizure type);

(6) Hematologic/immunologic disorders, (such as hemophilia, sickle cell disease, aplastic anemia, agammaglobulinemia);

(7) Heart conditions, (such as aortic coarctation, transposition of the great vessels);

(8) Urologic conditions, (such as extrophy of bladder);

(9) Gastrointestinal conditions, (such as Hirschprung's Disease, omphalocele, gastroschisis);

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(10) Orthopedic problems, (such as clubfoot, scoliosis fractures, poliomyelitis);
(11) Metabolic disorders, (such as panhypopituitarism);
(12) Neoplasms, (such as leukemia, retinoblastoma); and
(13) Multisystem genetic disorders, (such as tuberosclerosis, neurofibromatosis).
(14) Autism Spectrum Disorder for a child or youth ages 0 to 21.

(E) Developmentally delayed -
(1) A child age birth to three years who is experiencing developmental delays equal to greater than 25 percent as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

(a) Cognitive development;
(b) Physical development (including vision and hearing);
(c) Language and speech development;
(d) Psychosocial development; and
(e) Self-help skills.

(2) One who has a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay.

(F) Multi-need - An individual who has a combination of two or more disabling conditions. Each condition, if considered separately, might not be severe enough to warrant case management, but a combination of the conditions would be of such severity to adversely affect development.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities and, hospitals.
Medicaid recipients may receive TCM services in more than one target group, or case management services from another program if the Agency determines this would not present a duplication of services.

_X__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000). Also excluded are individuals receiving services in an Institution for Mental Disease (IMD).

Areas of State in which services will be provided (§1915(g)(1) of the Act):

_X__ Entire State
___ Only in the following geographic areas:

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Targeted Group 3 Disabled Children

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X__ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

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Targeted Group 3 Disabled Children

activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - o services are being furnished in accordance with the individual's care plan;
    - o services in the care plan are adequate; and
    - o changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

___Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Target Group 3: Disabled Children
Case management providers must be certified as a Medicaid provider meeting the following criteria:

(A) Demonstrated capacity to provide all core elements of case management:

(1) assessment,
(2) care/services plan development,
(3) linking/coordination of services, and
(4) reassessment/follow-up.

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(B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(C) Demonstrated experience with the target population.

(D) An administrative capacity to insure quality of services in accordance with state and federal requirements.

(E) A financial management system that provides documentation of services and costs.

(F) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(G) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(H) Demonstrated capacity to meet the case management service needs of the target population.

Individual case managers must meet the following minimum qualifications:

(A) A Bachelor of Arts or a Bachelor of Science degree, or

(B) A registered nurse, and

(C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

The Alabama Department of Mental Health (ADMH) case management provider for Disabled Children (Target 3, Subgroup B - SED) must be Regional Boards incorporated under Act 310 of Comprehensive Community Health Centers who have demonstrated the ability to provide targeted case management directly, or the ADMH. TCM providers for Disabled Children through ADMH must be certified and provide services through a contract with "ADMH". Act 310 provides for the formation of for the formation of public corporation to contract with ADMH in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

The ADMH case management provider for Disabled Children (Target Group 3, Subgroup A- Intellectually Disabled and Target 3, Subgroup D14- Children with Autism Spectrum Disorder) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Act who have demonstrated ability provide targeted case management services directly, be ADMH employees, or other contractors of ADMH. Act 310 provides for the formation of public corporation to contract with ADMH in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.

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- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 3 Disabled Children

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State/Territory: _Alabama_

TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Foster Children (Children in the Care, Custody, or Control of the State or Receiving State Agencies). The population to be served consists of children age 0-20 or until the individual reaches age 21 who are receiving preventive, protective, family preservation or family reunification services from the State, or any of its agencies as a result of State intervention or upon application by the child's parent (s), custodian(s), or guardian(s);or children age 0-20 or until the individual reaches age 21 who are in the care, custody or control of the State of Alabama, or any of its agencies due to:

(A) The judicial or legally sanctioned determination that the child must be protected by the State as dependent, delinquent, or a child in need of supervision as those terms are defined by the Alabama Juvenile Code, Title 12, Chapter 15, Code of Alabama 1975; or

(B) The judicial determination or statutorily authorized action by the State to protect the child from actual or potential abuse under the Alabama Juvenile Code, Title 26, Chapter l4, Code of Alabama 1975, or other statute; or

(C) The voluntary placement agreement, voluntary boarding home agreement, or an agreement for foster care, between the State and the child's parent(s), custodian(s), or guardian.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

_**X**__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_**X**_ Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_**X**__ Services are not comparable in amount duration and scope (§1915(g)(1)).

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

___Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Target Group 4: Foster Children
Case management providers must be certified as a Medicaid provider meeting the following criteria:

(A) Demonstrated capacity to provide all core elements of case management:
  (1) assessment,
  (2) care/services plan development,
  (3) linking/coordination of services, and
  (4) reassessment/follow-up.

(B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(C) Demonstrated experience with the target population.

(D) An administrative capacity to insure quality of services in accordance with state and federal requirements.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

(E) A financial management system that provides documentation of services and costs.

(F) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(G) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(H) Demonstrated capacity to meet the case management service needs of the target population.

Individual case managers must meet the following minimum qualifications:

(A) A Bachelor of Arts or a Bachelor of Science degree, preferably in a human services field, or

(B) A registered nurse, and

(C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 4 Foster Children

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 5 Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
The population to be served consists of Medicaid-eligible women in need of maternity and perinatal services.

A person in this target group may reside in her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Case management services are those services which will assist Medicaid-eligible pregnant women of any age in need of maternity services in gaining access to needed medical, social, educational, and other services.

Case management services are those services which will assist program eligible perinatal women in gaining access to needed medical, social, educational and other services. Perinatal is defined as the period inclusive of pregnancy through two years postpartum, to the child's second birthday. Services to the parent (primary caregiver) could be available during this same two year period following the birth of the child.

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 5 Pregnant Women

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of three months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 5 Pregnant Women

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

___Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Case management providers must be certified as a Medicaid provider meeting the following criteria:

(A) Demonstrated capacity to provide all core elements of case management:
  (1) assessment,
  (2) care/services plan development,
  (3) linking/coordination of services, and
  (4) reassessment/follow-up.

(B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(C) Demonstrated experience with the target population.

(D) An administrative capacity to ensure quality of services in accordance with state and federal requirements.

(E) A financial management system that provides documentation of services and costs.

(F) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(G) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(H) Demonstrated capacity to meet the case management service needs of the target population.

(I) Credentialed by appropriate certifying agency(ies).

Individual case managers must meet the following minimum qualifications:

(A) A Bachelor of Arts or a Bachelor of Science degree in social work from a school accredited by the Council on Social Work Education, or

(B) A registered nurse, and

(C) Training in a case management and/or nurse home visiting curriculum approved by the Alabama Medicaid Agency.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 5 Pregnant Women

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The

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need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 6 AIDS/HIV-Positive Individuals

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
AIDS/HIV-Positive Individuals
The population to be served consists of Medicaid-eligible individuals who have been diagnosed as having AIDS or being HIV-positive as evidenced by laboratory findings.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, or residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
_ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
_ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Case management services are those services which will assist Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive as evidenced by laboratory findings in gaining access to needed medical, social, educational, and other services.

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 6 AIDS/HIV-Positive Individuals

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 6 AIDS/HIV-Positive Individuals

___Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Target Group 6: AIDS/HIV-positive individuals
Case management providers must be certified as a Medicaid provider meeting the following criteria:

(A) Demonstrated capacity to provide all core elements of case management:
- (1) assessment,
- (2) care/services plan development,
- (3) linking/coordination of services, and
- (4) reassessment/follow-up.

(B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
(C) Demonstrated experience with the target population.
(D) An administrative capacity to insure quality of services in accordance with state and federal requirements.
(E) A financial management system that provides documentation of services and costs.
(F) Capacity to document and maintain individual case records in accordance with state and federal requirements.
(G) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
(H) Demonstrated capacity to meet the case management service needs of the target population.

Individual case managers must meet the following minimum qualifications:

(A) A Bachelor of Arts or a Bachelor of Science Degree in social work from a school accredited by the Council on Social Work Education, or
(B) A registered nurse, and
(C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 6 AIDS/HIV-Positive Individuals

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 6 AIDS/HIV-Positive Individuals

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 7 Adult Protective Service

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Adult Protective Service Individuals
The population to be served consists of individuals 18 years of age or older who are:

(A) At risk of abuse, neglect, or exploitation as defined in Section 38-9-2 Code of Alabama, 1975; or mentally incapable of adequately caring for himself or herself and his or her interests without serious consequences to himself or herself or others, or who, because of physical or mental impairment, is unable to protect himself or herself from abuse, neglect, exploitation, sexual abuse, or emotional abuse by others, and who has no guardian, relative, or other appropriate personable, willing, and available to assume the kind and degree of protection and supervision required under the circumstances

(B) At risk of institutionalization due to his/her inability or his/her caretaker's inability to provide the minimum sufficient level of care in his/her own home.

A person in one of these targeted groups may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, residential programs. Targeted case management services may be provided to clients receiving case management through a waiver so long as both case managers are performing different types of activities and functions based upon the case managers' distinct focus. The case manager's documentation must provide a clear distinction between waiver case management and targeted case management activities.

_**X**__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_**X**__ Entire State
__ _ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
__ _ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_**X**__ Services are not comparable in amount duration and scope (§1915(g)(1)).

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 7 Adult Protective Service

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 7 Adult Protective Service

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

___Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Target Group 7: Adult Protective Service Individuals

Individual case managers must meet the following minimum qualifications:

(A) A Bachelor of Arts or a Bachelor of Science Degree, preferably in a human services field, and

(B) Eligible for state social work licensure or exempt from licensure.

(C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 7 Adult Protective Service

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 7 Adult Protective Service

activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 8 Individuals who meet the eligibility criteria for the HCBS Technology Assisted (TA) Waiver for Adults

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Individuals who meet the eligibility criteria for the HCBS Technology Assisted (TA) Waiver for Adults.
The target group for the TA waiver is individuals who are 21 years of age or older with complex medical conditions. These individuals are ventilator-dependent or have a tracheostomy.

A person in this target group may reside in his/her own home, the household of another, or a supervised residential setting and in total care environments, such as nursing facilities, hospitals, and residential programs. Targeted case management services will not be provided to clients receiving case management through a waiver.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
__ Only in the following geographic areas

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
__ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 8 Individuals who meet the eligibility criteria for the HCBS Technology Assisted (TA) Waiver for Adults

- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up – The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contracts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - o services are being furnished in accordance with the individual's care plan;
    - o services in the care plan are adequate; and

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 8 Individuals who meet the eligibility criteria for the HCBS Technology Assisted (TA) Waiver for Adults

- changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

___Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Target Group 8: Individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults.

Targeted case management providers for the individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults, must demonstrate experience with the target population in completing medical psychosocial assessments and case plans, coordination of services, provision of referral and follow-up services and be employed in a non-institutional health care setting and must be certified as a Medicaid provider meeting the following criteria:

(A) Demonstrated capacity to provide all core elements of case management:
  (1) assessment**,**
  (2) care/services plan development,
  (3) linking/coordination of services, and
  (4) reassessment/follow-up

(B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(C) Demonstrated case management experience with the target population.

(D) An administrative capacity to ensure quality of services in accordance with state and federal requirements.

(E) A financial management system that provides documentation of services and costs.

(F) Capacity to document and maintain individual case records in accordance with state and federal requirements.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 8 Individuals who meet the eligibility criteria for the HCBS Technology Assisted (TA) Waiver for Adults

(G) Demonstrated ability to assure a referral process consistent with Section 1902(a)(23), freedom of choice of provider.

(H) Demonstrated capacity to meet the case management service needs of the target population

Individual case managers must meet the following minimum qualifications:

(A) A Bachelor of Arts or Bachelor of Science, or

(B) A Registered Nurse, and

(C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 8 Individuals who meet the eligibility criteria for the HCBS Technology Assisted (TA) Waiver for Adults

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 9 Individuals who meet the eligibility criteria for Substance Use Disorders

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
The target group to be served consists of Medicaid-eligible individuals who have a diagnosed substance use disorder or substance induced disorder, in accordance with criteria set forth by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, and who meet the following additional criteria.

(1) Individuals who:
- (a) Have been unable to independently maintain a sustained period of recovery after repeated treatment episodes; or
- (b) Have little or no access to community resources necessary to support sustained recovery efforts; or
- (c) Have co-morbid conditions, as mental illness, emotional disorders, intellectual disabilities, medical conditions, sensory impairments, or mobility impairments; or
- (d) Have significant responsibility for the care of dependents, as well as themselves.

(2) Individuals who are residing in a supervised residential setting, transitioning to an approved community setting following an institutional stay, residing in his/her own home, or the household of another are eligible for Target Group 9.

The target group does not include individuals who are inmates of public institutions. Also excluded are individuals receiving services in an Institution for Mental Disease (IMD).

Medicaid recipients may receive TCM services in more than one target group or case management services from another program if the Agency determines this would not present a duplication of services.

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X__ Entire State
___ Only in the following geographic areas

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 9 Individuals who meet the eligibility criteria for Substance Use Disorders

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
- taking individuals history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

- Reassessment/follow-up – The case manager shall evaluate through interviews and observations the progress of the individuals toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the individuals will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

❖ Development (and periodic revision) of a specific case plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 9 Individuals who meet the eligibility criteria for Substance Use Disorders

- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the case plan; and

❖ Monitoring and follow-up activities:
- Ongoing activities and contacts that are necessary to ensure the case plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's case plan;
  - services in the case plan are adequate; and
  - changes in the needs or status of the individual are reflected in the case plan. Monitoring and follow-up activities include making necessary adjustments in the case plan and service arrangements with providers.

___Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Target Group 9: Individuals who meet the eligibility criteria for Substance Use Disorders.

Case management providers for the target group must be certified by and provide services through a contract with the Alabama Department of Mental Health and have the following qualifications:

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 9 Individuals who meet the eligibility criteria for Substance Use Disorders

(A) Demonstrated capacity to provide all core elements of case management:

(1) assessment,
(2) care/services plan development,
(3) linking/coordination of services, and
(4) reassessment/follow-up.

(B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(C) Documented work experience with the target population.

(D) An administrative capacity to insure quality of services in accordance with state and federal requirements.

(E) A functional financial management system that provides documentation of services and costs.

(F) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(G) Demonstrated ability to assure a referral process consistent with Section 1902a(23) of the Social Security Act, freedom of choice of provider.

(H) Demonstrated capacity to meet the case management service needs of the target population.

Individual case managers must meet the following minimum qualifications:

(A) A Bachelor of Arts or Bachelor of Science, or
(B) A Registered Nurse, and
(C) Training in a case management curriculum approved by the Alabama Medicaid Agency and the Alabama Department of Mental Health.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 9 Individuals who meet the eligibility criteria for Substance Use Disorders

Freedom of Choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

3. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

4. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
__X__ **T**arget group consists of eligible individuals with substance use disorders. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with substance use disorders receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the case plan have been achieved; (v) Whether the individual has declined services in the case plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 9 Individuals who meet the eligibility criteria for Substance Use Disorders

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 10 Disabled Children and Severely Mentally Ill Adults High Intensity Care Coordination

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

A. The population to be served consists of individuals age 0-20 or until the individual reaches age 21 considered to be disabled as defined in the following two subgroups and who require a multi-disciplinary service team from more than one child-serving agency or who have one or more co-occurring diagnoses:
   (1) Autism Spectrum Disorder (ASD)
      a. children/youth requiring a multi-disciplinary service team from more than one child-serving agency or who have one or more co-occurring diagnoses.
   (2) Seriously Emotionally Disturbed (SED); and

   In order to meet the definition of seriously emotionally disturbed, the recipient must meet the following criteria for (I & II) *or* (I & III):

I. Diagnosis:
   a. Must have a DSM/ICD diagnosis. A primary diagnosis of a "Z" code, substance use, autism spectrum disorder, developmental/intellectual disability, organic mental disorder, or traumatic brain injury does not meet the criteria.

II. Jeopardy of being Separated from Family (Out-of-Home Placement):
   a. Still residing in the community but in jeopardy of being separated from family as the result of a serious emotional disturbance.

III. Functional Impairments/Symptoms/Risk of Separation – Must have a. **or** b. **or** c. as the result of a serious emotional disturbance:
   a. Functional Impairment – Must have substantial impairment in one of the following capacities to function (corresponding to expected developmental level):
      i. Autonomous Functioning: Performance of the age appropriate activities of daily living, e.g., personal hygiene, grooming, mobility;
      ii. Functioning in the community – e.g., relationships with neighbors, involvement in recreational activities;
      iii. Functioning in the Family or Family Equivalent – e.g., relationships with parents/parent surrogates, siblings, relatives;
      iv. Functioning in School/work – e.g., relationships with peers/teachers/co-workers, adequate completion of school work.
   b. Symptoms – Must have one of the following:
      i. Features associated with Psychotic Disorders
      ii. Suicidal or Homicidal Gesture or Ideation
   c. Risk of Separation:
      i. Without treatment, there is imminent risk of separation from the family/family equivalent or placement in a more restrictive treatment setting.

B. The population to be served consists of individuals age 18 and older considered to be disabled as defined in the following subgroup and who require a multi-disciplinary service team from more than one agency or who have one or more co-occurring diagnosis:
   a. Severely Mentally Ill (SMI):
      The population to be served consists of functionally limited individuals 18 years of age or older with multiple needs who have been assessed by a qualified professional and have been found to require mental health case management. Such persons have a diagnosis included in the ICD-10 as appropriate to date of service (other than primary developmental/intellectual disabilities, autism spectrum disorder, organic mental disorder, traumatic brain injury, or substance abuse), impaired role functioning, and a documented lack of capacity for independently accessing, and sustaining involvement with needed services.

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TARGETED CASE MANAGEMENT SERVICES
Targeted Group 10 Disabled Children and Severely Mentally Ill Adults High Intensity Care Coordination

Medicaid recipients may receive TCM services in more than one target group, or case management services from another program if the Agency determines this would not present a duplication of services.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000). Also excluded are individuals receiving services in an Institution for Mental Disease (IMD).

Areas of State in which services will be provided (§1915(g)(1) of the Act):

X Entire State

___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted Case Management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Reassessment/follow-up - The case manager shall evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

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activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - o services are being furnished in accordance with the individual's care plan;
    - o services in the care plan are adequate; and
    - o changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring - The case manager will ascertain on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Target Group 10: Autism Spectrum Disorder (ASD) Children, Serious Emotional Disturbance (SED) Children, and Severely Mentally Ill (SMI) Adults.
Case management providers must be certified as a Medicaid provider meeting the following criteria:

(A) Demonstrated capacity to provide all core elements of case management:
- (1) assessment,
- (2) care/services plan development,
- (3) linking/coordination of services, and
- (4) reassessment/follow-up.

(B) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
(C) Demonstrated experience with the target population.
(D) An administrative capacity to insure quality of services in accordance with state and federal requirements.
(E) A financial management system that provides documentation of services and costs.
(F) Capacity to document and maintain individual case records in accordance with state and federal requirements.
(G) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
(H) Demonstrated capacity to meet the case management service needs of the target population.

Individual case managers must meet the following minimum qualifications:
- (A) A Bachelor of Arts or a Bachelor of Science degree, or
- (B) A registered nurse, and
- (C) Training in a case management curriculum approved by the Alabama Medicaid Agency.

The Alabama Department of Mental Health (ADMH) case management provider (for Target 10, ASD) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Act who have demonstrated ability to provide targeted case management services directly, be ADMH employees, or other contractors of ADMH. Providers must be certified by the Alabama Department of Mental Health and provide services through a contract with ADMH. Act 310 provides for the formation of public corporation to contract with the Alabama Department of Mental Health in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

The ADMH case management provider (for Target 10, SED and SMI) must be either Regional Boards incorporated under Act 310 of the 1967 Alabama Act who have demonstrated ability to provide targeted case management services directly, or the Alabama Department of Mental Health. Providers must be certified by the Alabama Department of Mental Health and provide services through a contract with ADMH. Act 310 provides for the formation of public corporation to contract with the Alabama Department of Mental Health in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

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Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
    - Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

Effective Date: 10/01/2015
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

State of Alabama
Self-Directed Personal Assistance Services State Plan Amendment

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. _____ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. **X** In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. _____ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

B. **X** Services included in the following Section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

The following are the 1915(c) Home and Community-Based Waiver Services to be self-directed:
Elderly and Disabled Waiver: Personal Care, Homemaker, Unskilled Respite, and Companion.
State of Alabama Independent Living Waiver: Personal Care, Personal Assistance, and Unskilled Respite
Alabama Community Transition Waiver: Personal Care, Homemaker, Unskilled Respite, and Companion
Technology Assisted Waiver for Adults: Personal Care/Attendant

iii. Payment Methodology

X The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

A. _____The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

A. __X__ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. _____ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

A program participant may elect to discontinue participation in the *Personal Choices* program at any time.

The following procedures serve as safeguards to ensure that the reasons for disenrollment are not related to abuse or similar concerns and that services are not interrupted during the transfer from *Personal Choices* to the participant's traditional waiver program.

It is the responsibility of the participant to initiate voluntary disenrollment by notifying his Counselor of such a decision. The participant may notify the Counselor of his desire to disenroll by phone or e-mail. The Counselor will document in the participant's record, the date of notification by the participant of their decision to disenroll. The Counselor will begin the disenrollment process within **5** business days from the date of notification. A face-to-face contact is required to discuss the following:

- To provide an opportunity for the Counselor to determine if the participant's health, safety, and welfare has been jeopardized during their enrollment
- To minimize unnecessary disenrollment if the Counselor can identify and resolve any problems that would enable continued enrollment and satisfaction with the program or confirm that the reasons for disenrollment cannot be resolved
- To obtain the signature of the participant to attest to his desire to disenroll

- To explain the processes and timeline for transfer back to the traditional service delivery option
- To ascertain the participant's choice of direct service providers
- To discuss the conversion of the individual budget back to traditionally authorized services and make necessary decisions related to accumulated funds

From the receipt of the request for voluntary disenrollment, the timeline for transfer from *Personal Choices* to the traditional waiver, when the participant's health and safety is not in jeopardy, may be from fifteen to forty-five days. The Counselor will have 5 days to begin the process of disenrollment and the transition to the traditional waiver program. The timeline may be extended up to 45 days if requested by the participant.

Personal Choices services will continue until transition to the traditional waiver is complete.

Once disenrolled, the participant must continue to receive traditional waiver services for a minimum of three months before re-enrollment in *Personal Choices* can be considered.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to traditional service delivery model are noted below.

At any time that it is determined that the health, safety and well-being of the participant is compromised by continued participation in the *Personal Choices* program, the participant may be returned to the traditional waiver program. Participants will be given an advance notice in writing of their return to the traditional waiver service. Although the decision to involuntarily disenroll the participant from the *Personal Choices* program may be appealed, the participant will begin to receive traditional waiver services until a decision is made on their appeal. The participant/representative has 15 days from the date of notification of disenrollment to file a request for an informal review of this decision. The ADSS or ADRS, respectively, depending upon the traditional waiver the participant is enrolled in, will make a decision within 30 days from receipt of the request for an informal review. If the informal review decision is unfavorable, the participant may appeal the decision within 60 days from the date of the written decision to disenroll the participant from the *Personal Choices Program* based in accordance with established Medicaid Fair Hearings Policy.

Program participants may be involuntarily disenrolled from the program for the following reasons:

1. Health, Safety and Well-being

   At any time that the Counselor, the traditional waiver case manager, or the operating agencies determine that the health, safety and well-being of the program participant is compromised or threatened by continued participation in the Personal Choices program, the participant will be disenrolled.

2. Change in Condition

   If the participant's ability to direct his/her own care diminishes to a point where they can no longer do so and there is no responsible representative available to direct the care, then the individual will be involuntarily disenrolled from the program.

3. Misuse of Monthly Allocation

   If the *Personal Choices* participant/representative choose the cash option and uses the monthly budgeted allocation to purchase items unrelated to personal care needs, fail to pay the salary of an employee, or fail to pay related state and federal payroll taxes, the participant/representative will receive a written warning notifying them that exceptions to the agreed upon conditions of participation are not allowed. The participant will be permitted to remain on the *Personal Choices* program, but will be assigned to a Financial Management Services Agency (FMSA), who will provide bookkeeping services for the participant. The participant/representative will be notified in writing that further failure to misuse funds allocated through the *Personal Choices* program will result in involuntary disenrollment from the program.

4. Under-utilization of Budget Allocation

   The FMSA is responsible for monitoring on a monthly basis the use of funds received on behalf of program participants. If the participant is underutilizing the monthly allocation or is not using the allocation according to their Personal Support Plans, the FMSA and Counselor will discuss the issues of utilization with the participant/representative. If the health and safety of the participant may be in jeopardy because of the under-utilization of the budget allocation, the participant will be returned to traditional waiver services.

5. Failure to Provide Required Documentation

   If a program participant/representative fails to provide required documentation of expenditures and related items as prescribed in the *Personal Choices Roles and Responsibility* tool, a written reminder will be sent from the FMSA to the participant/representative. If the participant/representative continues to fail to provide required documentation after a written notice is given, the individual will be disenrolled from the program.

The participant/representative will receive written advance notification of disenrollment and the reasons for the actions. After disenrollment, the participant/representative cannot utilize funds allocated by the *Personal Choices program.*

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

A program participant may be involuntarily disenrolled as a participant in the *Personal Choices* program if the circumstances specified by the State occur.
It is the responsibility of the Counselor to notify the waiver case manager immediately when the participants' health and safety may be jeopardized by their continued enrollment in the *Personal Choices* program. The Counselor will begin the disenrollment process as soon as practicable to ensure the health and safety of the participant and a seamless transition to the traditional waiver.

The waiver case manager must ensure that traditional services are reinstated prior to the discontinuance of the *Personal Choices* program. The waiver case manager will perform a re-assessment of the participant's level of care needs in order to resolve any identified health and safety issues.

The Counselor must make a face-to-face visit to gather the following information in support of the involuntary disenrollment of the participant:

- The extent of the health and safety issue which necessitates the need for involuntary disenrollment
- To identify and resolve any problems that may enable continued enrollment or confirm that the reasons for involuntary disenrollment cannot be resolved
- To obtain the participant's signature acknowledging that they understand that they will no longer be participating in the *Personal Choices* program
- To explain the processes and timeline for transfer back to the traditional waiver program
- To determine the participant's choice of direct service provider agencies
- To discuss the conversion of the individual budget back to the traditional waiver services and make necessary decisions related to accumulated funds

Personal Choices services will continue until transition to the traditional waiver is complete.

Once disenrolled, the participant must continue to receive traditional waiver services for a minimum of three months before re-enrollment in *Personal Choices* can be considered.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

The State places no additional restrictions on participant living arrangements.

viii. Geographic Limitations and Comparability

A. __**X**__ The State elects to provide self-directed personal assistance services on a statewide basis.

The targeted population for statewide self-directed personal assistance services are participants enrolled in the Alabama Community Transition (ACT) Waiver.

B. __**X**__ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:

The targeted geographic areas for Medicaid-eligible beneficiaries from the Elderly and Disabled (E&D) Waiver are the following ten counties in Alabama: Baldwin, Bibb, Escambia, Fayette, Greene, Hale, Lamar, Mobile, Pickens and Tuscaloosa.

The targeted geographic areas for Medicaid-eligible beneficiaries from the State of Alabama Independent Living (SAIL) Waiver are the following seven counties in West Alabama: Bibb, Fayette, Greene, Hale, Lamar, Pickens, and Tuscaloosa.

C. _____ The State elects to provide self-directed personal assistance services to all eligible populations.

D. _____ The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Marguerite's comment: This is checked only if the State is targeting a sub-population within the 1915(c) waivers.

To be eligible for *Personal Choices*, the individual must:

- Be currently enrolled in either the E&D, SAIL, or the ACT waiver and meet the medical and financial requirements for participation in those waivers
- Reside in one of the counties served by the E&D or SAIL waivers.

To be a participant in *Personal Choices*, the individual/representative must:

- Give informed consent to participate
- Be able to understand the rights, risks, and responsibilities of managing their own care or if unable to make decisions independently have a willing representative who understands the rights, risks and responsibilities of managing the care of the participant with a cash allowance
- Be willing to complete a Personal Support Plan with the help of a counselor.

E. ____ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _X_ The State elects to provide self-directed personal assistance services to 1,734 (insert number of) participants, at any given time.

This number represents the approximate number of available slots in the E&D and SAIL waivers in the counties. This number will allow participation in Personal Choices by enrollees of both the EDW and the SAIL waivers. The number of participants enrolled is limited by the number of slots allocated to the counties.

This number also represents 200 statewide participants from the ACT Waiver.

ix. Assurances

A. The State assures that there are traditional personal assistance services, comparable in amount, duration and scope, to self-directed personal assistance services.
B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.
C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:
   i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
   ii. Are entitled to and are receiving home and community-based services under a Section 1915(c) waiver; or
   iii. May require self-directed personal assistance services; or
   iv. May be eligible for self-directed personal assistance services.

D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a Section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting the following criteria:

i. Appropriately assesses and counsels individuals prior to enrollment;

ii. Provides appropriate counseling, information, training and assistance to ensure that participants are able to manage their services and budgets;

iii. Offers additional counseling, information, training or assistance, including financial management services:

1. At the request of the participant for any reason; or
2. When the State has determined the participant is not effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every three years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of Section 1902(a)(27) of the Social Security Act, and Federal regulations 42 CFR 431.107, governing provider agreements, are met.

I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:

i. Objective and evidence based.

ii. Applied consistently to participants.

iii. Open for public inspection.

iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.

v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.

vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.

vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.

viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.

ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

The State delegates the responsibility for developing the self-directed personal assistance service plan to the counselors employed by the designated Operating Agency and does not delegate any portion of that authority to any other Medicaid State Plan service provider.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

i. How it will conduct activities of discovery, remediation and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

ii. The system performance measures, outcome measures and satisfaction measures that the State will monitor and evaluate.

Personal Choices has been designed to promote quality in operations. The Center for Medicare/Medicaid Services' (CMS) Quality Framework is the cornerstone for monitoring and improving the quality of the program. The CMS Quality Framework focuses on a participant-centered foundation that supports access, choice, and the health and safety of the participant. The *Personal Choices* Quality Management Plan integrates the Quality Framework with the Scripps Center *Guide to Quality in Participant Directed Services,* and the Cash and Counseling Performance Indicators.

The essence of this Plan is to identify quality strategies as described in the CMS Quality Framework and then to monitor the status and the effectiveness of the processes through the discovery of problems or concerns; remediation or resolutions of problems identified; and improvement within the program or a reevaluation of program strategies.

Design Elements of the Quality Management Plan for *Personal Choices*

Accountability
The Alabama Medicaid Agency will maintain administrative oversight responsibilities for the Quality Management Plan. The Alabama Department of Senior Services (ADSS) and the ADRS will be responsible for the actual management of quality activities defined in the plan.

The ADSS and ADRS will maintain primary oversight of the following activities and will:

- Monitor the Counselor/FMSA to the degree necessary to ensure compliance with participant direction of their care and appropriate fiscal and programmatic procedures
- Identify modifications and apply edits to the *Personal Choices* data system to create reports, prevent erroneous billing and allow a continual system of review
- Provide support to the Counselor and FMSA to enable effective training.
- Monitor the cost of the *Personal Choices* program by reviewing the Medicaid HCFA-64 report on a quarterly basis.
- Establish a quality improvement process under the leadership of the *Personal Choices* Project Director.
- Develop and submit an annual quality assurance report to CMS.

Each of the stakeholders also has an integral role to play in quality management. These include the participant, the participant's employees, the Counselor and the FMSA as well as the administering and operating agencies.

Quality Improvement Committee
The Quality Improvement Committee (QIC) will monitor all aspects of quality in the *Personal Choices* program. The QIC includes the participants/representative, the participant's employees, the Counselor, the FMSA as well as representatives from Medicaid, the ADSS, and ADRS staff. This committee will set performance indicators, review program operations and results make recommendations for program changes and develop strategies for program improvement. This committee will meet monthly for the first 6 months and quarterly thereafter.

To achieve an optimal level of quality within this program, substantial involvement from participants and family members is necessary. Therefore, a Local Quality Improvement Committee will be established in the pilot area that will include the *Personal Choices* participants/representatives, family members, employees, Counselors, and FMSA representatives. The ADSS and ADRS staff will attend meetings as needed. The Local Quality Improvement Committee will meet monthly for the first 6 months and quarterly thereafter. The meetings will be "open meetings" that will involve the above committee members as appropriate.

Education and Training

Counselors are required to receive comprehensive, competency-based training from ADSS and ADRS staff or a designee. Once trained, the Counselor will provide a comprehensive, competency-based training to all participants/representative before the individual budget is developed. Outreach and participant/representative education activities will also be provided on an as needed.

Training materials will be developed and modified as needed, based upon the participant's level of competency. The Quality Improvement Committee will review training materials and revise as indicated.

Peer Support Group

Personal Choices recognizes the importance of relationships as a measure of quality. A Peer Support Group is offered to allow participants the opportunity to share their experiences and meet other individuals in their community.

Discovery Elements of the Quality Management Plan for *Personal Choices*

Accountability

ADSS and ADRS will monitor all aspects of the *Personal Choices* demonstration project to assure compliance with the project design. The operating agencies will conduct participant surveys to monitor the level and quality of participant direction and the adequacy of the training curriculum to enable successful participant direction. The Project Director or designee will respond to possible quality problems identified through any channel by establishing a Project Team to examine the available data, study the work process in question, and develop a corrective action plan. The Project Team will include a representative from the Medicaid Agency Long Term Care Quality Assurance Division. The Project Director or designee, along with the Project Team will monitor implementation of changes and subsequent data collection to determine whether problems have been resolved.

Performance Indicators
The Performance Indicators will be used to measure program performance that may occur at the service or provider level. The Performance Indicators are the tools utilized to monitor and track program activities and processes to ensure that participant choice and satisfaction in services and service delivery is achieved. The Performance Indicators are person-centered and focus on positive outcomes for the participants.

The Performance Indicator Reports will describe the results of data gathered using the Performance Indicators, the source of the data, the frequency in which the data is reviewed, and who assists in analyzing the data.

The Performance Indicator Reports will ensure the following key components:

- Enrollment processes are proceeding as planned
- Enrollees receive their first allowance payment timely
- Number of disenrollments are minimized
  - Costs of providing Personal Choices services are comparable with the cost of providing the EDW, SAIL, and ACT Waiver services.
- Participants are satisfied with their care arrangements and paid caregivers
- Unmet needs of participants are reduced
- Participants' health is not adversely affected
  - Reports provide indicators which support the reduction or delay of clients' admissions to nursing homes.

Remediation and Improvement Elements of the Quality Management Plan for *Personal Choices*
Quality Improvement Committee (QIC)

Incident Management and Abuse Prevention
The plan for the *Personal Choices* program is defined in policy and is the responsibility of the operating agencies and the Project Director. The procedures are consistent with current Alabama State law and reporting procedures. To further ensure the participants' health and safety, criminal background checks of providers at no cost to the participant will be required.

The Quality Improvement Committee will serve as the Incident Management Review team and will be tasked with the monthly review of all incident reports, develop recommendations or changes to the program, and monitor the program changes to ensure implementation.

All participants, family members, and Counselors will receive training in incident reporting and management before receiving or providing services. The core elements of the training will provide information on reporting abuse, neglect, and exploitation, how participants can report incidents, and to whom to report incidents.

xii. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

Participant Protections

The Personal Choices program will provide participant protections to include: information to participants, participant training and skills assessment, counseling services, financial management services, development of emergency Back-up plans, development of an incident reporting system and access to program staff. Participants are required to use counseling and financial management services in order to assume responsibility for their care and financial management. The Counselor will train, coach, and provide technical assistance to participants as needed. The training and technical assistance will help participants use the budget to effectively meet their care needs, avoid overspending as well as prevent the under-utilization of their allocated budget.

The FMSA, as the employer agent, will assist participants to pay their employees and assure compliance with state and federal labor and tax laws. The FMSA will provide a method of receiving funds from the state and making the funds available for the participants' budgets.

Orientation

An orientation to the Personal *Choices Role and Responsibilities tool is* required for all participants prior to the disbursement of the initial monthly budget. The intent of the orientation is to provide participants with the tools they need to effectively and safely manage their services. Counselors will be responsible for providing this mandatory training session for participants enrolled in the program. Participants will receive a program manual to provide additional information to support the training objectives.

During this orientation, risks are identified and risk mitigation plans are developed through the use of three primary tools: 1) the *Personal Choices Roles and Responsibilities*, 2) the *Self-Assessment* and 3) the *Health and Safety Planning Checklist*. In addition, participants are provided the *Support Network Checklist* tool, to assist them in identifying others resources who may be able to provide help and support and thereby also mitigate risk. One of the most important uses of this tool is in the development of a back-up plan but the tool may also be used to address other risk issues.

Back-up Plan

Personal Support Plans **must** include an emergency backup plan identifying the arrangements that have been made for the provision of services and/or supplies in the absence of critical planned services and supports. Each *Personal Choices* participant is required to develop a Back-up plan as part of his Personal Support Plan. The Back-up plan should describe the alternative service delivery methods that will be used under either of the following circumstances: 1) if the primary employees fail to report for work or otherwise cannot perform the job at the time and place required, 2) if the participant experiences a personal emergency, or 3) if there is a community-wide emergency (e.g., requiring evacuation). The personal emergency portion of the Back-up plan will allow the participant to identify circumstances that would cause an emergency for him based upon his unique needs. The Back-up plan must also address ways to assure that the needs of the individual are met should an unexpected shortage of funds occur. The Back-up Plan should also address if the representative is no longer able to serve as the participant's representative. The Counselor must attest to the viability of the Back-up plan before services can begin and the budget is released.

In the event of a disaster, the *Personal Choices* participant will have access to assistance from the Alabama Emergency Management Agency (EMA). Data will be shared with EMA on all *Personal Choices* participants who are high risk or participants with special needs in order to assure that EMA has expedient access to the participant in a threatening situation.

Peer Supports

Personal Choices participants are encouraged to identify a peer and/or become affiliated with a Peer Group. The Counselor will facilitate linkages to Peer Group. It is the responsibility of the participant to make contact and foster the relationship with a peer group.

Representatives

Participants may choose to manage their own personal support plans, or may appoint a representative to assist them. Counselors and outreach staff will provide and/or make available education and information to enable either model. All participants have the option of choosing one individual to act as a representative (friend, caregiver, family member, or other person) to assume budget and care management responsibilities.

Representatives may not work for the participant or be paid by the participant with monthly budget funds. Participants may also receive assistance with their *Personal Choices* responsibilities without appointing a friend, caregiver, family member, or other person as a representative, but these individuals cannot sign documents, speak for or otherwise act on behalf of the participant.

B. The tools or instruments used to mitigate identified risks are described below.

There are three levels of risk assessment used to identify potential risks to participants.

Level 1: HCBS Waiver Assessment
Participants in the *Personal Choices* program must be participants in the E&D, SAIL, or ACT waivers. Therefore, prior to enrollment in the Personal Choices program, each participant will receive an HCBS waiver plan of care based on an assessment of need as determined by the HCBS Waiver Assessment tool that includes an identification of risks and potential mitigation strategies. The waiver case manager will continue to play a role in the participant's overall plan of care through the HCBS traditional waiver, and will continue to assess needs and risks as required by the respective waiver protocol.

Level 2: Orientation Self Assessment
All participants in *Personal Choices* must take part in an initial orientation prior to the release of the budget. This orientation begins with a self-assessment process, using three tools.

The first tool is the *Personal Choices Roles and Responsibilities,* which provides a detailed description of the roles and responsibilities of the participant in the program including a detailed description of the roles, responsibilities and support functions of the Counselor and FMSA. This document will be thoroughly reviewed with the participant and/or the representative to ensure that there is a clear understanding of the responsibilities related to the health and safety and mitigation of risks to be assumed by the participant.

The second tool is the *Self-Assessment,* which asks participants to indicate their understanding and ability to implement each of the roles and responsibilities detailed in the *Personal Choices Roles and Responsibilities tool*. Depending on the responses, the Counselor and participant will formulate a plan for ensuring the participant can effectively manage each of the roles and responsibilities. Other potential strategies may include additional training and/or the use of an informal or formal representative.

The third tool is the *Health and Safety Planning Checklist.* This instrument lists many common risk factors, ranging from physical and cognitive disabilities to social issues such as isolation. For each identified risk, the participant is alerted to the nature of the potential risk and prompted with examples to develop a plan to mitigate that potential risk.

Level 3: Ongoing Monitoring by Counselor and FMSA
The Counselor will monitor the Personal Support Plan to ensure that participation in the program does not compromise the health and well being of the participant. The Counselor will initiate contacts to the participant as needed to monitor the quality of self-directed care, to provide support and assistance, and to assure that essential needs are met. These contacts will be conducted as needed, but not less than monthly during the first six months of participation.

The FMSA will document at least monthly amounts spent for each participant/representative receiving an allowance to assure that money is spent on appropriate items identified in the Personal Support Plan, or for items related to personal care needs when discretionary funds are spent. Monitoring may be performed more frequently whenever problems or potential problems are identified. Problems associated with the monthly allowance such as misuse or under-utilization of the funds, failure to pay assistants as required, failure to comply with applicable state and federal employer laws, failure to submit documentation of expenditures, theft of checks mailed to participant/representative or other problems will be reported in writing to the operating agencies immediately.

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

Individuals who choose to participate in the *Personal Choices* program will be provided with individualized supports to enable them to manage their own services to the largest extent possible.

These supports, and the manner in which they will be delivered, will be generated from a person-centered planning process facilitated by the Counselor utilizing the Self Assessment tool.

The participant/representative will develop a Personal Support Plan to specify how the monthly budget will be used to meet the participant's care needs, and how other identified needs might be met through generic and community supports. Information from the Self Assessment tool that takes place during orientation will serve as a primary source of information regarding potential risks and the plans that are developed to mitigate the risk. The results of this process will be documented in the service plan and updated annually or more frequently if needed.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

Counselors will provide support for technical assistance in order to facilitate the development of the risk management plan by the participant/representative, if any, and others from whom the participant may seek guidance.

Counselors will not assume responsibility for developing the risk management plan, but will review and approve the plan to ensure that proposed services are adequate, purchases are cost-effective and related to the participant's needs, and that an emergency Back-up Plan is in place. Additionally, the Counselor will assess the overall Personal Support Plan for potential risks and risk mitigation strategies. The Counselor reviews the proposed personal support plan with the participant/representative and others identified by the participant as a method to assess the participant/representative's ability to assume service management responsibilities and to further generate discussion around risk management.

xiii. Qualifications of Providers of Personal Assistance

A. __X__ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

B. _____ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

xiv. Use of a Representative

A. __X__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i. _____ The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

B. _____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

A. __X__ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

B. _____ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. __X__ The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. ____ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with Section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. __X__ The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR Section 74.40 – Section 74.48.)

iii. ____ The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. _____ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

State of Alabama
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

_____

_____

Regular Post Eligibility

The state applies post-eligibility treatment of income rules to PACE participants who are eligible under section 1902(a)(10)(A)(ii)(VI) of the Act (42 C.F.R. §435.217 of the regulations).
Yes ____ No __X__.
Post-eligibility for states that have elected to apply the rules to PACE participants

Note: Section 2404 of the Affordable Care Act mandated that, for the five-year period beginning January 1, 2014, the definition of an "institutionalized spouse" in section 1924(h)(1) of the Social Security Act include all married individuals eligible for certain home and community-based services (HCBS), including HCBS delivered through 1915(c) waivers. As of this writing, the ACA provision has been extended through December 31, 2019. This means that married individuals eligible in the eligibility group described at 42 C.F.R. §435.217 must have their post-eligibility treatment-of-income rules determined under the rules described in section 1924(d). Because states that elect to apply post-eligibility treatment-of-income rules to PACE participants may only do so to the same extent the rules are applied to individuals eligibility under 42 C.F.R. §435.217, application of the post-eligibility treatment-of-income rules must be applied to married individuals receiving PACE services consistent with the provisions described herein under "Spousal post-eligibility" so long as the amendment to section 1924 of the Act made by the ACA remains in effect.

1. **1634 and SSI States**

   The State applies the post-eligibility rules to individuals who are receiving PACE services and are eligible under 42 C.F.R. §435.217 consistent with the rules of 42 C.F.R. §435.726, and, where applicable, section 1924 of the Act. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

1. Allowances for the maintenance needs of the individual (check one):
   1. The amount deducted is equal to:
      (a) _____The SSI federal benefit rate
      (b) _____Medically Needy Income Level (MNIL)
      (c) _____The special income level standard for the institutionalized individuals eligible under section 1902(a)(10)(A)(ii)(V) of the Act

      (d) _____Percentage of the Federal Poverty Level: _____%
      (e) _____Other (specify):_____
   2. _____The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
   3. _____The following formula is used to determine the needs allowance:
      _____
      _____

Note: If the amount protected for a PACE enrollee in item 1 is equal to, or greater than, the PACE enrollee's income, enter N/A in items 2 and 3.

2. Allowance for the maintenance needs of the spouse:
   The amount deducted for the PACE enrollee's spouse is equal to:
   1. ____ The SSI federal benefit rate
   2. ____ Optional State Supplement Standard
   3. ____ Medically Needy Income Level Standard
   4. ____ The following dollar amount (provided it does not exceed the amount(s) described in 1-3): $_____
   5 . ____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
   6. ____ Not applicable (N/A)

3. Allowance of the maintenance needs of the family (check one):
   1. ____ AFDC need standard
   2. ____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

4. Allowance for medical and remedial care expenses, as described in 42 CFR 435.726(c)(4).

2. 209(b) States,

The State applies the post-eligibility rules to individuals who are receiving PACE services and are eligible under 42 C.F.R. §435.217 consistent with the rules of 42 C.F.R. §435.735, and, where applicable, section 1924 of the Act. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

1. Allowances for the maintenance needs of the individual (check one):
   1. The amount deducted is equal to:
      (a) _____The SSI federal benefit rate
      (b) _____Medically Needy Income Level (MNIL)
      (c) _____The special income level standard for the institutionalized individuals eligible under section 1902(a)(10)(A)(ii)(V) of the Act
      (d) _____Percentage of the Federal Poverty Level: _____%
      (e) _____Other (specify):_____
   2._____The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
   3._____The following formula is used to determine the needs allowance:
      _____
      _____

Note: If the amount protected for a PACE enrollee in item 1 is equal to, or greater than, the PACE enrollee's income, enter N/A in items 2 and 3.

2. Allowance for the maintenance needs of the spouse:

The amount deducted for the PACE enrollee's spouse is equal to:

1.____ The more restrictive income standard established under 42 C.F.R. §435.121
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Level Standard
4.____ The following dollar amount (provided it does not exceed the amount(s) described in 1-3): $_____
5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ Not applicable (N/A)

3. Allowance of the maintenance needs of the family (check one):

1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

4. Allowance for medical and remedial care expenses, as described in 42 CFR 435.735 (c)(4).

Spousal Post Eligibility

State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance consistent with the minimum monthly maintenance needs allowance described in section 1924(d), a family allowance, for each family member, calculated as directed by section 1924(d)(1)(C), and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.
Yes ____ No __X__

Note: states must elect the use the post-eligibility treatment-of-income rules in section 1924 of the Act in the circumstances described in the preface to this section.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).____The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B).____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

(C)_____The following formula is used to determine the needs allowance:

_____
_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1. X Rates are set at a percent of the amount that would otherwise been paid for a comparable population.
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

RATE METHOD

Program of All-inclusive Care for the Elderly (PACE)
For Sites Operating Under Medicare and Medicaid Capitation

Alabama uses an actuarial firm to calculate the AWOP.

Alabama's monthly capitation rate for PACE services is set at less than 100% of the AWOP for an equivalent non-enrolled population group.

The AWOP is established by evaluating populations that are at least 55 years old who meet nursing home level of care, and include:
a. Individuals who are residing in nursing homes on a long-term basis, **and**
b. Individuals who meet the nursing home level of care but are receiving services in a home and community-based setting

The projected nursing home and home and community-based service components plus state plan services are blended to establish an AWOP for Medicaid Only and Dual Eligible populations.

And

State Plan Services
State plan services are covered Medicaid services authorized through the State Plan (excluding nursing facility and home-and community-based services).

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) X MAT as described and limited in Supplement 4 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020, and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT. "For the period of October 1, 2020, through September 30, 2025 Medication Assisted

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Treatment (MAT) to treat Opioid Use Disorder (OUD) is covered exclusively under section 1905(a)(29)."

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

Intake Evaluation
Initial clinical evaluation of the recipient's request for assistance. Substance abuse recipients undergo standardized psychosocial assessment. The intake evaluation presents psychological and social functioning, recipient's reported physical and medical condition, the need for additional evaluation and/or treatment, and the recipient's fitness for Medication Assisted Treatment (MAT) services.

Medical Assessment and Treatment
Face-to-face contact with a recipient during which a qualified practitioner provides psychotherapy and/or medical management services. Services may include physical examinations, evaluation of co-morbid medical conditions, development or management of medication regimens, the provision of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services, or the provision of educational services related to management of an opioid use disorder.

Individual Counseling
The utilization of professional skills by a qualified practitioner to assist a recipient in a face-to-face, one-to-one psychotherapeutic encounter in achieving specific objectives of treatment or care for a mental health and/or an opioid use disorder. Services are generally directed toward alleviating maladaptive functioning and emotional disturbances relative to a mental health and/or opioid use disorder, and restoration of the individua l to a level of functioning capable of supporting and sustaining recovery. Individual Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services.

Family Counseling
A recipient focused intervention that may include the recipient, his/her collateral* and a qualified practitioner. This service is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of an opioid use disorder that interferes with the recipient's personal, familial, vocational, and/or community functioning. Family counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary.

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

Group Counseling
The utilization of professional skills by a qualified practitioner to assist two or more unrelated recipients in a group setting in achieving specific objectives of treatment or care for an opioid use disorder. Services are generally directed toward alleviating maladaptive functioning and behavioral, psychological, and/or emotional disturbances, and utilization of the shared experiences of the group's members to assist in restoration of each participant to a level of functioning capable of supporting and sustaining recovery. Group Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic service strategies.

Treatment Plan Review
Review and/or revision of a recipient's individualized opioid use disorder treatment plan by a qualified practitioner who is not routinely directly involved in providing services to the recipient. This review will evaluate the recipient's progress toward treatment objectives, the appropriateness of services being provided, and the need for a recipient's continued participation in treatment.

Opioid Use Disorders Update
A structured interview process that functions to evaluate a recipient's present level of functioning and/or presenting needs. The assessment is used to establish additional or modify existing diagnoses, establish new or additional goals, assess progress toward goals, and/or to determine the need for continued care, transfer, or discharge.

Psychoeducational Services
Structured, topic specific educational services provided to assist the recipient and the families* of recipients in understanding the nature of the identified opioid use disorder, symptoms, management of the disorder, how to help the recipient be supported in the community and to identify strategies to support restoration of the recipient to his/her best possible level of functioning. Services that involve the participation of a non-Medicaid eligible are for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

Medication Administration
The administration of medication, including the use of FDA approved medications for the use of opioid use disorders, to recipients who have a diagnosed opioid use disorder. Medication is administered to support the recipient's efforts to restore adequate functioning in major life areas that have been debilitated as a result of opioid addiction. This service includes medication administration and concurrent related medical and clinical services.

Peer Support Services
Peer Support services provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Recovery Support Specialists. Peer Support service actively engages and empowers an individual and his/her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual (and family when appropriate) with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to individuals (and family when appropriate) to promote recovery, resiliency and healthy lifestyles and to reduce identifiable and increase healthy behaviors intended to prevent relapse and promote long-term recovery. Peer supports provide effective techniques that focus on the individual's self-management and decision making about healthy choices, which ultimately extend the members' lifespan.

b) Please include each practitioner and provider entity that furnishes each service and component service.

See information listed below under c).

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

The eligible practitioners, the qualifications required and services furnished for those who may provide MAT services under the Rehabilitation Option Program are as follows:

- A **physician** licensed under Alabama law to practice medicine or osteopathy; Medical Assessment and Treatment; Intake Evaluation; Crisis Intervention; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Opioid Use Disorders Assessment Update; Psychoeducational Services; Medication Administration.
- A **physician assistant** licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners; Medical Assessment and Treatment; Intake Evaluation; Crisis Intervention; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Opioid Use Disorders Assessment Update; Psychoeducational Services; Medication Administration.
- A **Certified Registered Nurse Practitioner** (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses; Medical Assessment and Treatment; Treatment Plan Review; Medication Administration.
- A **Certified Registered Psychiatric Nurse Practitioner** (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses; Intake Evaluation; Crisis Intervention; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Opioid Use Disorders Assessment Update; Psychoeducational Services; Medication Administration.
- A **psychologist** licensed under Alabama law; Intake Evaluation; Crisis Intervention; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Opioid Use Disorders Assessment Update; Psychoeducational Services.
- A **professional counselor** licensed under Alabama law; Intake Evaluation; Crisis Intervention; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Opioid Use Disorders Assessment Update; Psychoeducational Services.

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

- A **certified social worker** licensed under Alabama law; Intake Evaluation; Crisis Intervention; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Opioid Use Disorders Assessment Update; Psychoeducational Services.
- A **marriage and family** therapist licensed under Alabama law; Intake Evaluation; Crisis Intervention; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Opioid Use Disorders Assessment Update; Psychoeducational Services.
- A **registered nurse** licensed under Alabama law who has completed a master's degree in psychiatric nursing; Intake Evaluation; Medication Administration.
- A **registered nurse** licensed under Alabama state law; Psychoeducational Services; Medication Administration.
- A **practical nurse** licensed under Alabama state law; Medication Administration.
- **Qualified Substance Abuse Professional (QSAP) I**: A Qualified Substance Abuse Professional I shall consist of: (i) An individual licensed in the State of Alabama as a: (I) Professional Counselor, Graduate Level Social Worker, Psychiatric Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Marriage and Family Therapist, Clinical Psychologist, Physician's Assistant, Physician; or (ii) An individual who: (I) Has a master's Degree or above from a nationally or regionally accredited university or college in psychology, social work, counseling, psychiatric nursing, and * (II) Has successfully completed a clinical practicum or has six month's post master's clinical experience; and * (III) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of date of hire. ; Intake Evaluation.
- **QSAP II** shall consist of: (i) An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Is licensed in the State of Alabama as a

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Bachelor Level Social Worker; or (III) Has a Bachelor's Degree from anationally or regionally accredited college or university in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (IV) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium. or (V) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (VI) obtains a substance use counselor certification credential from the Alabama Association of Addiction Counselors, National Association Drug Abuse Association, or International Certification and Reciprocity Consortium within 30 months of hire, and (VII) participates in ongoing weekly supervision from an assigned QSAP 1 that is documented and appropriately filed in their personnel file for auditing purposes until counselor certification is obtained.

- **QSAP III** shall consist of: (i) An individua l who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Participates in ongoing supervision by a certified or licensed QSAP I for a minimum of one (1) hour individual perweek until attainment of a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, or Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse,Inc. which shall be obtained within thirty (30) months of hire; Psychoeducational Services.
  - Certified Recovery Support Specialist (CRSS) must meet the following minimum qualifications: (i) Certified by ADMH as a Certified Recovery Support Specialist (CRSS) within six (6) months ofdate of hire, (ii) and has 2 years verified lived experience and (iii) Concurrent participation in clinical supervision by a licensed orcertified QSAP I; Peer Support Services.

i. Utilization Controls

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

__X__ Quantity limits

_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

All of forms of drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) are covered. These drugs may be/are included in the scope of the Preferred Drug List, may require clinical criteria, and may have quantity limitations.

The state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT may be overridden based on medical necessity, and are as follows:

The limits for Medication Administration are hard coded and is only overridden every seven years for "leap year" when there is a day 366. The remaining MAT related services have soft limits that can be overridden for medical necessity. Medical necessity will be established from the recipient's condition at the time of the request, not the diagnosis alone.

Intake Evaluation

Billing Unit:	Episode
Maximum Units:	Unlimited
Billing Restrictions:	May not be billed in combination with Treatment Plan Review (H0032)

Medical Assessment and Treatment

Billing Unit:	15 minutes
Maximum Units:	6 per day, 52 per year

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Individual Counseling

Billing Unit: 1 unit
Maximum Unit: 1 per day, 52 per year
Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Medication Administration (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Family Counseling

Billing Unit: 1 episode=minimum of 60 minutes (90846-HF/ 90847HF)
1 episode=minimum of 90 minutes (90849-HF)
Maximum Units: 1 episode per day, 104 per year
Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Medication Administration (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Group Counseling

Billing Unit: 1 episode=minimum of 90 minutes
Maximum Units: 1 episode per day, 104 per year
Billing Restrictions: May not be billed in combination with Partial Hospitalization (H0035), Medication Administration (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to theCategorically Needy (continued)

Treatment Plan Review

Billing Unit:	15 minutes
Maximum Units:	1 event with up to 2 units every 6 months, 4 per year (for DMH-MI providers) 1 event with up to 2 units every 6 months, 4 per year (for DMH-SASD providers)
Billing Restrictions:	None

Mental Health and Opioid Use Disorders Update

Billing Unit:	15 minutes
Maximum Units:	8 units per day, 56 units per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90791)

Psychoeducational Services

Billing Unit:	15 minutes
Maximum Units:	416 units per year *8 per day for services provided to an individual recipient's family* *8 per day for services provided to a group of recipients' families*
Billing Restrictions:	May not be billed in combination with Medication Administration (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014) and H0035-HF Partial Hospitalization.

Medication Administration

Billing Unit:	One day
Maximum Units:	365 per year for H0020 (oral Methadone, Buprenorphine). 1 per month for J2315 (injectable Vivitrol)

Peer Support Services

Billing Unit:	15 minutes

State of Alabama

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Maximum Units: Limited to 20 units per day (individual) and 8 units per day (group). 2,080 units per year for group services and 2,080 units per year for individual services.

Billing Restrictions: None

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Revision: HCFA-AT-81-37 (BPP)

State ALABAMA

Attachment 3.1-B
Page 1

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S):

The following ambulatory services are provided.

Not in system
4/11/00
3.1B

State ALABAMA

Attachment 3.1-B
Page 2

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

1. Inpatient hospital services other than those provided in an institution for mental diseases or tuberculosis	☐	Provided
	☐	No limitations
	☐	With limitations*
2.a. Outpatient hospital services.	☐	Provided
	☐	No limitations
	☐	With limitations*
2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic	☐	Provided
	☐	No limitations
	☐	With limitations*
3. Other laboratory and X-ray services.	☐	Provided
	☐	No limitations
	☐	With limitations*
4.a. Skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older.	☐	Provided
	☐	No limitations
	☐	With limitations*

* Description provided on attachment.

State ALABAMA

Attachment 3.1-B
Page 3

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	☐ Provided ☐ No limitations ☐ With limitations*
4.c. Family planning services and supplies for individuals of child-bearing age.	☐ Provided ☐ No limitations ☐ With limitations*
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.	☐ Provided ☐ No limitations ☐ With limitations*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.	
a. Podiatrists' Services	☐ Provided ☐ No limitations ☐ With limitations*

* Description provided on attachment.

Tobacco Cessation Counseling Services for Pregnant Women

4. d 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician; and

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or*

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*describe if there are any limits on who can provide these counseling services

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: No limitations With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt should be explained below.

Please describe any limitations:

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

b. Optometrists' Services
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

c. Chiropracters' Services
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

d. Other Practitioners' Services
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

b. Home health aide services provided by a home health agency.
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

* Description provided on attachment.

State ALABAMA

Attachment 3.1-B
Page 5

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

c.	Medical supplies, equipment, and appliances suitable for use in the home.	☑ Provided ☐ No limitations ☐ With limitations*
d.	Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.	☑ Provided ☐ No limitations ☐ With limitations*
8.	Private duty nursing services.	☑ Provided ☐ No limitations ☐ With limitations*
9.	Clinic services.	☑ Provided ☐ No limitations ☐ With limitations*
10.	Dental services.	☑ Provided ☐ No limitations ☐ With limitations*

* Description provided on attachment.

Revision: HCFA-AT-81-37(BPP)

State ALABAMA

Attachment 3.1-B
Page 6

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

11. Physical therapy and related services.

a. Physical therapy. ☐ Provided
☐ No limitations
☐ With limitations*

b. Occupational therapy. ☐ Provided
☐ No limitations
☐ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist. ☐ Provided
☐ No limitations
☐ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs. ☐ Provided
☐ No limitations
☐ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

b. Dentures.
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

c. Prosthetic devices.
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

d. Eyeglasses.
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan.

a. Diagnostic services.
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

b. Screening services. ☐ Provided
☐ No limitations
☐ With limitations*

c. Preventive services. ☐ Provided
☐ No limitations
☐ With limitations*

d. Rehabilitative services. ☐ Provided
☐ No limitations
☐ With limitations*

14.a. Services for individuals age 65 or older in institutions for tuberculosis.

(1) Inpatient hospital services. ☐ Provided
☐ No limitations
☐ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

(2) Skilled nursing facility services. ☐ Provided
☐ No limitations
☐ With limitations*

(3) Intermediate care facility services. ☐ Provided
☐ No limitations
☐ With limitations*

14.b. Services for individuals age 65 or older in institutions for mental diseases.

(1) Inpatient hospital services. ☐ Provided
☐ No limitations
☐ With limitations*

(2) Skilled nursing facility services. ☐ Provided
☐ No limitations
☐ With limitations*

* Description provided on attachment.

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE MEDICALLY NEEDY

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c. Intermediate care facility services.

/ / Provided / / No limitation / / With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

/ / Provided / / No limitation / / With limitations*

b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

/ / Provided / / No limitation / / With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

/ / Provided / / No limitation / / With limitations*

17. Nurse-midwife services.

/ / Provided / / No limitation / / With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

/ / Provided / / No limitation / / Provided in accordance with section 2302 of the Affordable Care Act

// With limitations*

*Description provided on attachment-

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S):_____

17. Nurse-midwife services.

☐ Provided

☐ No limitations

☐ With limitations*

18. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation

☐ Provided

☐ No limitations

☐ With limitations*

b. Services of Christian Science Nurses

☐ Provided

☐ No limitations

☐ With limitations*

c. Care and services provided in Christian Science sanitoria

☐ Provided

☐ No limitations

☐ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S):

d.	Skilled nursing facility services provided for patients under 21 years of age.	☐ Provided ☐ No limitations ☐ With limitations*
e.	Emergency hospital services	☐ Provided ☐ No limitations ☐ With limitations*
f.	Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of an R.N.	☐ Provided ☐ No limitations ☐ With limitations*

* Description provided on attachment.

State of Alabama
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

Methods For Assuring High Quality of Care

The following methods shall be used by the Alabama Medicaid Agency in administering the Medical Assistance Program to ensure that medical, remedial care, and service provided are of high quality, properly utilized and based on acceptable professional medical standards, State and Federal laws and regulations.

1. Fiscal agent will perform quality review and utilization procedures consistent with good business practices to meet Alabama Medicaid requirements. The activities of the fiscal agent will be regularly reviewed through an Alabama Medicaid audit and in depth quality assurance case review on a sample basis.

2. Peer Review Committees have been established in Alabama for the purpose of settling disputes related to charges made for professional and other medical assistance services. Problems submitted to Peer Review Committees may originate with the Alabama Medicaid Agency, its fiscal agent, providers and recipients. Additional Peer Review Committees may be established as needed.

   a. Peer Review Committees act independently of the fiscal agent and representatives of Alabama Medicaid Agency.

   b. No member of a Peer Review Committee who has an ownership interest in a facility under review will participate in committee action for the facility.

   c. A member of a Peer Review Committee shall not review a case on which he or a partner or associate is the attending physician or dentist or in which he has had professional responsibility.

   d. Medical peer review is the responsibility of the Medical Association of the State of Alabama. They sponsor a statewide peer review system for resolution of physician provider problems referred to them by the Alabama Medicaid Agency and others.

   e. Dental Peer Review Committees shall be maintained in the state according to the districts established by the Alabama Dental Association. These committees shall function as appeal bodies on requests from the Alabama Medicaid Agency, Utilization Review Committees, and patients. Matters not resolved by these committees shall be referred, where possible malpractice is involved, to the State Board of Dental Examiners.

f. Pharmacy Peer Review Committees are maintained in several districts to ensure adequate coverage of the entire state. Each committee shall have registered active pharmacists who are participants in the state Medicaid drug program, selected by the Alabama Medicaid Agency Pharmaceutical Program Administrator. The committees shall determine whether established drug standards and accepted principles are being followed and aid in monitoring proper drug utilization within the Medicaid pharmacy program. Unusual findings detected by the fiscal agent or the Alabama Medicaid Agency in cost, frequency of service, and volume or quality of drug service, shall be referred to a Pharmaceutical Review Committee, if a satisfactory solution cannot be reached with a pharmacy provider.

g. An Optometric Peer Review Committee will be maintained in the state by the Alabama Medicaid Agency. The committee shall meet at least twice each calendar year to discuss problems and complaints relative to optometric services within the Alabama Medicaid Program. It shall also function as an appeal body on request of the Alabama Medicaid Agency, optometric providers, and Medicaid recipients. Prior authorization requests from optometrists denied by Alabama Medicaid shall be submitted for consultation to the peer review committee before a final determination is made.

3. Each agency, organization, or institution providing care or services in the Alabama Medicaid program, must have a utilization review plan approved by the Alabama Medicaid Agency or its designated agent.

a. The Alabama Medicaid Agency shall have a Utilization Review Committee to examine problems brought before it that are related to medical care and services rendered to Medicaid recipients by providers.

Effective Date: 01/01/86

b. The Bureau of Licensure and Certification, Department of Public Health, has been designated, through an agreement with the Agency, to monitor facility utilization review activities on extended care services.

c. Utilization review for dental services is a part of the dental professional review program.

d. The Alabama Medicaid Agency monitors utilization review activities concerned with evaluation and supervision of nursing and other services provided by home health agencies.

e. Utilization review for pharmaceutical services is a part of the pharmacy professional review program or monitored by

the Alabama Medicaid Pharmacy Program in cooperation with the fiscal agent. Other monitoring activities are carried out by the Alabama Medicaid Agency in cooperation with the fiscal agent.

Effective Date: 01/01/86

f. Hospital inpatient utilizational review will be the responsibility of the Agency and/or its designated agent.

Effective Date: 10/01/82

g. Medical review for Skilled and Intermediate Care nursing facilities to include ICF/MR and ICF/MD is the responsibility of the Alabama Medicaid Agency. Independent professional utilization review for Free-Standing ICF/MR and ICF/MD is the responsibility of the Alabama Medicaid Agency.

4. Additional procedures for assuring high quality care include the following:

a. Patient and provider profiles and other pertinent data will be developed through data processing for the Alabama Medicaid Agency by the fiscal agent. The profiles will be used for program control and reporting purposes.

b. Members of the Alabama Medicaid Agency staff shall make scheduled and unscheduled visits, as necessary, to approved Medicaid providers to evaluate medical care and resolve problems that may arise.

c. Fiscal agent provider relations personnel will help resolve provider claim processing problems.

d. A liberal drug formulary published as the Alabama Drug Code Index (ADCI) shall be used. This publication will permit adequate pharmaceutical selections of drugs and their utilization without precipitating undesirable restrictions in the practice of medicine.

e. Evaluation and supervision of nursing and other services provided by State Home Health Agencies will be carried out by the Bureau of Public Health Nursing, Alabama Department of Public Health, under an agreement with the Alabama Medicaid Agency. Consultation evaluation and supervision of nursing and other services provided by all other home health agencies will be carried out by the Alabama Medicaid Agency.

Effective Date: 01/01/88

f. All home health records are subject to on-site audits and in-house reviews by representatives of the Alabama Medicaid Agency.

5. The Alabama Medicaid Agency Quality Control unit is responsible for monitoring Medicaid program effectiveness. Through its findings, administrators may identify and eliminate dollar losses by effecting corrective action in program operations

a. Alabama Medicaid Agency shall form a Corrective Action Committee to monitor the Medicaid program eligibility, claims processing, and third party liability procedures to identify and eliminate deficiencies in these functions.

b. The committee shall by July 31st of each year prepare and submit to the Federal Regional Medicaid Director, a report on its error analysis and a corrective action plan.

6. A state Medical Care Advisory Committee shall participate with the Commissioner of Medicaid in policy development and program administration, including the seeking of recipient participation in the Alabama Medicaid Program.

a. The Commissioner, Alabama Medicaid Agency, shall arrange for committee representation from licensed physicians and others from the health and medical care professions familiar with the medical needs of low income population groups. Representatives of consumer groups and of the public shall be included on the committee.

b. The State Health Officer and the Commissioner, Department of Human Resources shall be permanent ex-officio members of the committee.

c. The Medical Care Advisory Committee shall meet semi-annually and at other times as required to advise the Commissioner of Medicaid on medical assistance matters brought before it.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA
METHODS OF PROVIDING TRANSPORTATION

Effective Date: 02/01/09

The Alabama Medicaid Agency assures that necessary transportation of recipients to and from sources of medical care will be provided as follows:

I. Non-emergency Transportation Services - Ambulance:

A. All non-emergency ambulance services rendered to eligible Alabama Medicaid recipients for trips over 100 miles one way, where medical care is received requires prior authorization. Certification that medical conditions warrant the use of ambulance services are required by the attending physician.

B. Non-emergency ambulance service is provided to eligible recipients who must be bed-confined or have debilitating physical condition(s) that require travel by stretcher only and require ground transportation to receive medical services.

Effective Date : 12/01/14

II. Non-emergency Transportation Services:

Any appropriate means of transportation which can be obtained without charge through volunteer groups, nonprofit organizations, public services, relatives or other persons is the preferred method of transportation. If transportation is not available without charge, the Alabama Medicaid Agency will make reimbursement for non-emergency transportation, with the exception of ambulance transports, directly to the recipient through an Electronic Benefit Transfer (EBT) system. The state will have on file the rates charged by the major transporters across the state. When a recipient requests assistance, the reimbursements will be issued based on the most cost-effective rate for the appropriate mode of transportation, considering the rates for the particular area and the options available to the requesting recipient.

The NEMT Program provides necessary non-ambulance transportation services to Medicaid recipients. Medicaid pays for rides to a doctor or clinic for medical care or treatment that is covered by Medicaid. The types of transportation being provided are: a) automobile (volunteer driver); b) friends; c) Medicaid recipient's/relative's vehicle; d) wheelchair van services; e) bus (commercial or city transit); f) airplane; and g) train service. Medicaid will not reimburse services if recipient has access to free transportation, except in the case of evident hardship.

NEMT – Call Center and NEMT staff are responsible for screening beneficiaries for eligibility for a ride.

Escorts are covered if their presence is required to assist a recipient during transport while at the place of treatment. Only one escort is covered per recipient in need and the recipient must prove an identifiable need for the escort. The escort cannot be an employee of a NEMT transporter. Medicaid allows escorts for recipients under the age of 21. Escort services are utilized in-state or out of state for recipients over 21 years of age when a physician's statement documents that an escort is required because the recipient is blind, deaf, intellectually disabled or mentally ill or physically handicapped to such a degree personal assistance is necessary.

The recipient or his/her representative arranges the ride by calling the Medicaid toll free number in advance of the need for the ride. Rides can also be arranged through a facility social worker.

A maximum of one round trip may be reimbursed per date of service per recipient, without prior authorized exception. The most inexpensive mode of transportation that meets the recipient's needs must be used. The recipient must be traveling to a Medicaid covered service with a Medicaid provider. Recipients must contact the Agency to request transportation assistance five days prior to the needed transportation or within 24 hours after urgent care appointments. Medicaid does not pay for ride to the emergency room for a problem that can wait until the doctor's office or clinic is open.

For out-of-state transportation, the recipient's physician must provide a statement that justifies the need for out-of-state services and assure that such services cannot be obtained in-state. The NEMT Coordinator requests this information from the recipient's physician. The Coordinator then provides this information to their supervisor who submits it for review to Alabama Medicaid's Medical Review Team who will approve or deny the need for out of state transportation. For long distance travel, the recipient's physician must certify that the treatment is not available locally and the location of the closest available treatment. When overnight travel is necessary, Medicaid pays for meals and lodging for the recipient and one escort (when authorized). Medicaid must receive receipts or confirmation of expenses before reimbursement can be made. Reimbursement will not exceed $50 per person, per day. NEMT reimbursements will be issued for transportation costs to and from covered necessary medical services for which the recipient has benefits available.

The NEMT system verifies eligibility, appointments, mode of transportation, calculates and issues reimbursements for the trip. NEMT reimburses ambulatory and wheelchair transportation. The least costly mode of transportation appropriate to the needs of the recipient must be used. A tiered fee payment structure is utilized based upon factors such as: mileage; clients physical, mental or medical condition; whether the beneficiary is ambulatory or recumbent; prevailing rates in the region; availability of transportation resources; level of appropriate transportation required; and whether they are transported by a family member, commercial carrier, or ambulance provider.
Internal audits are performed by NEMT Staff.

NEMT is provided under the administrative option and is matched at 50%.

III. Non-emergency Transportation Services – Other:

Non-Emergency Medical Transportation for clients receiving allowable mental health services at Community Mental Health Centers are provided through contract with the Alabama Department of Mental Health (DMH).

Medicaid reimburses DMH as stated in Attachment 4.19-B, Page 14.a, Section 27.

The Alabama Medicaid Agency attests that all minimum requirements that ensure any provider (including a transportation network company) or individual driver of non-emergency transportation to medically necessary services receiving payments under such plan (but excluding any public transit authority), outlined in 1902(a)(87) of the Consolidated Appropriations Act, 2021 are met.

IV. Emergency Transportation Services - Ambulance:

All emergency ambulance transportation must be medically necessary and reasonable. No payment may be made for emergency ambulance services if some other means of transportation could be utilized without endangering the recipient's health.

A. Emergency ambulance services are provided to eligible recipients between:

(1) Scene or address of emergency and hospital.
(2) Nursing home and hospital.
(3) Local hospital and specialized hospital.
Example: From Montgomery to University of Alabama Hospital in Birmingham.

B. Certification that medical conditions warrant the use of ambulance services are required by the attending physician.

V. Air Transportation Services:

A. Air Transportation services are covered for adults and children.

B. Air transportation may be rendered only when basic and advanced life support land ambulance services are not appropriate.

C. All air transportation services must be approved by Alabama Medicaid prior to payment.

State: Alabama

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Effective Date: 02/01/01

Transplant services and associated immunosuppressive drugs are covered by the Alabama Medicaid Agency as defined below:

Group I includes medically necessary corneal transplants and does not require prior approval. These services are limited to routine benefit and payment limitations.

Group II includes medically necessary heart, lung, heart/lung, liver, liver/small bowel, small bowel, kidney, pancreas, and pancreas/kidney transplants. All transplants in this group require prior approval based on medical criteria contained in the Alabama Medicaid Transplant Manual. In order to be approved, transplants must be therapeutically proven effective and considered nonexperimental, and are limited to within the geographic boundaries of the State of Alabama. If there is no instate transplant facility that has the medical expertise/staffing to perform the transplant, Medicaid may approve the transplant to be performed out of state.

Group III includes medically necessary bone marrow transplants which require prior approval. Approval is based on medical criteria contained in the Alabama Medicaid Transplant Manual. Bone marrow transplants must be therapeutically proven effective and considered nonexperimental, and are limited to within the geographic boundaries of the State of Alabama. If there is no instate transplant facility which has the medical expertise/staffing to perform the transplant, Medicaid may approve the transplant to be performed out of state.

Group IV includes any medically necessary nonexperimental EPSDT- referred organ transplants. These include transplants which have been determined to be nonexperimental and necessary to treat or ameliorate a condition identified in a screening.

Procedures must be performed at a transplant center in which transplants are routinely performed by an integrated team of surgeons and medical support staff and which is in compliance with all applicable federal, state or local laws regarding organ acquisition and transplantation, equal access and nondiscrimination.

Payment methodology for bone marrow, liver, liver/small bowel, small bowel, lung, heart/lung, heart, kidney, pancreas, and pancreas/kidney transplants is outlined in Attachment 4.19-B in the State Plan.

State: ALABAMA

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Effective Date: 01/01/98
As an alternative, Medicaid may use an approved Prime Contractor. Medicaid's approved Prime Contractor will be responsible for the coordination and reimbursement for all Medicaid reimbursable organ transplants with the exception of cornea transplants as described in Attachment 4.19B in the State Plan. The Alabama Medicaid Agency's approved Prime Contractor must meet the following requirements:

1. Be certified for participation in the Medicare/Medicaid Program.

2. Be licensed as a hospital by the state of Alabama in accordance with current rules contained in the Alabama Administrative Code Chapter 420-5-7.

3. Be an established in-state transplant facility.

4. Capable of performing all Medicaid-covered transplants with the exception of cornea transplants.

5. Have the necessary physicians and other medical support personnel with the expertise to provide coordination and reimbursement for each type of Medicaid-covered transplant.

6. Be in compliance with applicable federal, state, or local laws or UNOS guidelines regarding organ acquisition and transplantation, equal access, and nondiscrimination.

State: ALABAMA

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Payment shall be made to the hospital providing the transplant and shall represent an aggregate of all services including pre-transplant evaluation; organ procurement; inpatient transplant services including hospital rooms, board, and ancillaries; professional fees; and normal post operative care.

Effective Date: 01/01/87

4. Cornea Transplant
   Although this procedure is technically a transplant, common usage does not ordinarily regard it in the category as true "organ transplants."

   It is mentioned here only for completeness and the requirements are only that a defect, diagnosed by an ophthalmologist, exists that can be corrected by a transplant. Nor prior authorization is required.

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Alabama enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
__X__ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

__X__ i. fee for service;
____ii. capitation;
__X__ iii. a case management fee;
__X__ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____vi. other. (Please provide a description below).

Citation	Condition or Requirement

a. Primary Care Case Management

Payments to Physicians:

Providers participating in the Primary Care Case Management program are reimbursed up to $2.60 per member per month in geographic regions of the State not operating under the Health Home authority. This rate is calculated as follows:

1. A variable rate based on the illness burden of each physician/practice's panel of patients as refleted on the Patient 1st Profiler report. Low risk patients which are those identified to have an acuity level of .9 or less are reimbursed $1.00 per member per month and high risk patients or those that are identified to have an acuity level of greater than .9 are reimbursed $1.60 per member per month.

2. For providing voice-to-voice access to medical advice and care for enrolled recipients 24 hours a day, seven days a week the provider is reimbursed $1.00 per member per month.

Providers participating in the Primary Care Case management program are reimbursed as follows in geographic regions of the State operating under the Health Home authority:

1. $.50 per member per month

2. An additional $8.00 per member per month is reimbursed for those patients identified as having a chronic health condition in accordance with approved State Plan page 3.1-H.

b. Payments for Care Management:

Providers of care management participating in the Primary Care Case Management program in geographic locations of the State not operating under the Health Home authority are reimbursed upon state-developed fee schedule rates which are the same for both governmental and private providers of case management and care coordination. Governmental providers are settled to cost annually.

Citation	Condition or Requirement

Providers of care management services for those patients identified as having a chronic health condition as per the approved State Plan page 3.1-H and who are in geographic locations that are designated as patient care networks are reimbursed $9.50 per qualified member per month.

Alabama operates a statewide PCCM managed care program for the state's Medicaid citizens. The Patient 1st Program began January 1, 1997 under the authority of a 1915(b) waiver and was operational until February 29, 2004. The State chose not to pursue renewal of the program at that time due to administrative and budgetary constraints. By February 2005, the Patient 1st Program was re-implemented statewide. The overarching goal of Patient 1st is to provide Alabama Medicaid recipients a medical home.

Within the Patient 1st Program, patients are assigned to a primary medical provider (PMP). The PMP is responsible for providing directly or through referral, necessary medical care. PMPs are paid a case management fee for each recipient and enhanced case management fees are paid for individual in certain categories. Alabama Medicaid provides feedback to providers in through a variety of reports.

Through Patient 1st, providers have access to resources that can enhance their case management. Recipients who qualify for Health Home for Individuals with Chronic Conditions can utilize care management services from the Patient Care Network, Community Mental Health Centers, Substance Abuse Providers and others.

All Patient 1st recipients can receive traditional case management for the PCCM program provided through a contract with the Alabama Department of Public Health (ADPH) or the Alabama Department of Human Resources (ADHR). ADPH and ADHR have licensed and trained case managers available throughout the State. Services provided are traditional case management services and include; assistance with understanding program requirements, help with transportation needs, assessment of the home environment and factors that may prevent the patient from being compliant with medical care protocols; mental health issues, child health issues such as understanding the need for preventive care, i.e. immunizations, etc.

Each patient that is referred into the case management system receives a risk assessment. Areas assessed include social supports, community supports, shelter/ nutrition/ communication resources, economic status, education/ language needs, physical health, mental health, parenting history and children's issues. From the risk assessment, a plan of action is developed in conjunction with the patient. Follow-up

Citation	Condition or Requirement

from the assessment and/or plan of action is provided back to the person making the referral into the system. ADPH and ADHR are paid through fee for service.

The State also has the ability to make direct referrals into the ADPH case management system for issues such as excessive emergency room use, patient dismissal, provider utilization, and patient education. In that State staff has contact with the patient, oftentimes issues are identified that may be preventing the patient from optimizing their medical home. Common reasons include lack of program understanding, transportation needs, and medical compliance.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

   If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

   __X__ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

   __X__ ii. Incentives will be based upon specific activities and targets.

   __X__ iii. Incentives will be based upon a fixed period of time.

   __X__ iv. Incentives will not be renewed automatically.

   __X__ v. Incentives will be made available to both public and private PCCMs.

   __X__ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

   ____ vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its

Citation	Condition or Requirement

initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

A Patient 1st Advisory Council was established during the design and implementation of the program in 1997. The Council is comprised of Medical Directors from the Patient Care Networks who are PMPs and represent the PMPs in their region. Federal Qualified Health Centers and Rural Health Clinics also have representation on the Council. The purpose of the Patient 1st Advisory Council is to address concerns presented by providers, recipients, and interested stakeholders in relation to Patient. Meetings are held regularly to go over issues and to obtain input for any changes to policy, including the components of the care management fee.

Recipients are also able to submit a concern about the program through a written complaint process.

AMA meets regularly with PCNA representatives including Medical Directors, Pharmacist, and Executive Directors. These staff represents the providers in their geographic regions and serves as a conduit between the agency and providers. These meetings will serve as the Patient 1st Advisory Council meetings.

AMA will meet annually with recipients and Medicaid eligibility staff to get feedback on the program operations.

AMA also meets regularly with provider organizations and Physician Task Force to seek input surrounding program changes.

The Alabama Medical Care Advisory Committee reviews all major program changes for the Medicaid program. Recipient advocates serve on this Committee.

1932(a)(1)(A)

5. The state plan program will _X_ /will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

Citation	Condition or Requirement

i. county/counties (mandatory) _____

ii. county/counties (voluntary)_____

iii. area/areas (mandatory)_____

iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. __X__The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. __X__The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. __X__The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. __X__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

1932(a)(1)(A)
42 CFR 438.6(c)

6. ____The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

Citation	Condition or Requirement
42 CFR 438.50(c)(6)	
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ____The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. ____The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis.

Section 1931 Children and Related Populations
Blind/Disabled Adults and Related Populations
Blind/Disabled Children and Related Populations
Aged and Related Populations

There may be individuals, decided on a case-by-case basis, which would not benefit from the program. For Patient 1st, these individuals typically have complex medical conditions that are being coordinated by a specialty care provider. Currently there are approximately 413exemptions approved for medical reasons. Additionally, there may be foster children or eligibles living in an institutional setting that might be exempted. Before any individual is exempted from participation, the provider serving that individual is given the opportunity to participate as a PMP for that patient.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. __X__ Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment.

Citation		Condition or Requirement
		(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.) Dual Eligible recipients may voluntarily enroll in Patient 1st. Recipients who voluntarily enroll may dis-enroll at any point. Voluntary enrollment is completed through a recommendation of a provider or through direct application of the recipient.
1932(a)(2)(C) 42 CFR 438(d)(2)	ii.	__X__ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii.	__X__ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.	__X__ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) CFR 438.50(3)(iii)	v.	__X__ Children under the age of 19 years who are in foster care or other out-42 of- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi.	__X__ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii.	__X__ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. The State assures that these recipients will be permitted to disenroll from the PCCM program on a month to month basis.

Citation	Condition or Requirement

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

The Children's Rehabilitation Service (CRS), a division of the Alabama Department of Rehabilitative Service, is a statewide organization of skilled professionals providing quality medical, rehabilitative, coordination, and support services for children with special health care needs and their families. Each of Alabama's 67 counties is served through a network of 15 community-based offices. Any child or adolescent younger than 21 years of age who is a resident of Alabama and has a special health care need is eligible for CRS. In Alabama, the Title V Maternal and Child Health Program is administer by the Alabama Department of Public health. This agency contracts with CRS to administer services to children and youth with special health care needs, making CRS Alabama's Title V Children with Special Health Care Needs Program. There is no automated way to identify these clients. There is a procedure for representatives for these individuals to notify the Patient 1st Program of the need for exemption. It is recognized that these individuals typically have complex medical conditions that are being coordinated by a specialty care provider.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
__X__iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

__X__i. yes

Citation	Condition or Requirement
	____ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; Self identification is used to exempt these clients. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; Self identification is used to exempt these clients. iii. Children under 19 years of age who are in foster care or other out-of-home placement; Eligibility database and coordination with Alabama Department of Human Resources iv. Children under 19 years of age who are receiving foster care or adoption assistance. Eligibility database and coordination with Alabama Department of Human Resources
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* The Patient 1st Program is based on the premise that patient care is best served by a medical home where a Primary Medical Provider (PMP) may coordinate care. If

Citation	Condition or Requirement

in the physician's opinion, the patient does not benefit from the Patient 1st Program, an exemption can be requested.

Either the PMP or the attending physician can submit this request on behalf of the patient. These are classified as medical on the number of exemptions.

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

i. Recipients who are also eligible for Medicare.

Aid Codes in eligibility system

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

The State coordinates with the Poarch Creek Indian Health Department to be sure any tribal members who are assigned to other Patient 1st providers are aware they can elect to receive services from the tribal clinic or be exempted. An opportunity is offered for recommendations, comments, and assistance whenever possible to meet specialized individual and community needs.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

NA

Citation	Condition or Requirement

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

NA

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Prior to automatic assignments, recipients are encouraged and provided the opportunity to select a PMP. If no PMP is selected the Agency automatically assigns enrollees to PMPs based on proximity and the following algorithm: newborn, sibling, past PMP, historical claims and random. Recipients who are added to the Medicaid eligibility file are notified of their Patient 1st assignment approximately within 5 days of assignment.. The assignment begins the first day of the month following the assignment. During the first month of the initial Patient 1st assignment recipients are encouraged to utilize the PMP for any needed care. During this month the recipient can utilize any other provider without a referral in order to allow the recipient ample time to

Citation	Condition or Requirement

change the PMP selection. PMP change request allow recipients to utilize the new PMP beginning on the day the change is requested. Beginning the PMP assignments the first day of the month following assignment allows the recipient to begin the relationship with the health home sooner while allowing care without referrals during the first month of the initial assignment allows the recipient time to change the PMP assignment. A listing of all providers serving that patient's county is included in the enrollment packet and is maintained on the Agency's website. Providers are also notified on a monthly basis of all patients on their panel including information on those who have been disenrolled. The assignment process takes into account the group practices and/or clinic affiliation.

The State regularly reviews assignments to ensure that the assignment process is working correctly. The assignment reason is compared to the information on file to ensure that the most appropriate assignment algorithm was applied.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Providers with a history of serving Patient 1st recipients can request an increase of 25% above these limits. Any expansion above 125% of these limits must be approved by the AMA Medical Director after a review of panel management, recipient outcomes, and area need.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Citation	Condition or Requirement

Each PMP FTE (defined as 40 hours per week on-site) is allowed 1200 patients. Physician extenders (e.g. nurse practitioners) can be used to extend the PMP's caseload by 400. Medicaid will align with the requirements of the Alabama Board of Medical Examiner's Administrative Code for Qualifications and Limitations of physicians collaborating with certified registered nurse practitioners (CRNPs) and physician assistants (PAs). Clinic provider caseloads are determined by the total number of FTE physicians and physician extenders. Providers who have historically seen a higher caseload of Medicaid patients may be authorized a caseload greater than allowed by this formula.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will__X__/will not____ use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

The Agency automatically assigns enrollees to PMPs based on proximity and the following algorithm: newborn, sibling, past PMP, historical claims and random. Recipients who are added to the Medicaid eligibility file are notified of their Patient 1st assignment by written correspondence

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

Citation	Condition or Requirement

Recipients can disenroll without cause at any time up to three times during a calendar year. If a recipient disenrolls from a PMP more than three times in a given calendar year the recipient may be reviewed for possible lock in to a single provider without the ability to disenroll without cause for 12 months. Recipients can notifiy the Agency by phone, letter or through the use of a web site. Additionally, recipients often select a new PMP and have that provider notify the agency of the change. These changes are effective the month following notification if received prior to the 15th of the month and the new provider can begin care of the recipient immediately following submission of the PMP Change Form.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

The Agency automatically assigns enrollees to PMPs based on proximity and the following algorithm: newborn, sibling, past PMP, historical claims and random.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State regularly reviews assignments to ensure that the assignment process is working correctly. The assignment reason is compared to the information on file to ensure that the most appropriate assignment algorithm was applied and is working properly. The State also tracks the reasons for PMP changes on a monthly basis through the MMIS to identify problems with assignments.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

Citation	Condition or Requirement

1. __X__ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. __X__ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. __X__ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   ___ This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   __X__ This provision is not applicable to this 1932 State Plan Amendment.

5. __X__ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   ___ This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will __X__/will not___ use lock-in for managed care.

2. The lock-in will apply for up to 12 months (up to 12 months).

3. Place a check mark to affirm state compliance.

   __X__ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

Citation	Condition or Requirement

Recipients may be considered for lock-in to a specific PMP without the ability to disenroll without cause for the following reasons:

More than three request for PMP changes within a calendar year
Behavior indicating drug seeking behavior

Recipients who are locked-in to a provider will be notified in writing and will be reviewed on a quarterly basis. Lock-in status will not apply for greater than 12 months.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:

- Independent Labs & Hospital Labs
- Mental Health Services
- Physicians: Anesthesiologists, Oral Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine
- Pregnancy-Related Services
- Independent Radiologists & Hospital Radiologists
- Targeted Case Management
- Ambulance
- Certified Emergency
- Dental
- Dialysis
- EEG/EKG Related Services
- End Stage Renal Disease
- EPSDT Development Diagnostic Assessment
- Routine Eye Exams
- Eyeglass & Other Lens Fittings
- Family Planning

Citation	Condition or Requirement

- Diabetic Supplies
- Gynecology/Obstetrics Services
- Hearing Aids
- Hospice
- Immunizations
- Physician Inpatient Consults/Visits
- Inpatient Hospital Services (per diem)
- Cancer treatments including Chemotherapy and Radiation

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not __X__ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. ____ The selective contracting provision in not applicable to this state plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. 3/31/2014)

Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date: 03-04-15
Attachment 3.1-H Page Number: 24

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

AL-14-0001

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

AL-12-011

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

AL HHS

State Information

State/Territory name:	**Alabama**
Medicaid agency:	Alabama Medicaid Agency

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:	Stephanie Lindsay
Title:	Administrative Procedures Officer
Telephone number:	(334) 242-5833
Email:	Stephanie.Lindsay@medicaid.alabama.gov

The primary contact for this submission package.

Name:	Stephanie Lindsay
Title:	Administrative Procedures Officer
Telephone number:	(334) 242-5833
Email:	

Stephanie.Lindsay@medicaid.alabama.gov

The secondary contact for this submission package.

Name:	Carolyn Miller
Title:	Associate Director, Project Development and Quality Improvement
Telephone number:	(334) 353-5539
Email:	Carolyn.Miller@medicaid.alabama.gov

The tertiary contact for this submission package.

Name:	Jerri Jackson
Title:	Director, Managed Care Division
Telephone number:	(334) 242-5630
Email:	Jerri.Jackson@medicaid.alabama.gov

Proposed Effective Date

04/01/2015 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
The initial Health Home State Plan Amendment was approved effective 7/1/2012 through 6/30/2014 in 21 counties. These Health Homes were named Patient Care Networks of Alabama (PCNA). Due to the success of the program, AMA wants to continue to achieve improved outcomes through expansion of this program statewide and plans to release an RFP to procure additional Health Homes in 2015 for 46 counties. Going forward in this SPA, these lead entities will be referred to as "Health Homes". AMA also plans to add Hepatitis C as a diagnosis.

The lead Health Home entity is a non profit organization that provides care coordination and transitional care services to recipients. Additionally, this entity coordinates health home services with the Health Care Team of Providers including PMPs, FQHCs, RHCs, Alabama Dept of Public Health (ADPH), and Community Mental Health Centers (CMHCs) to provide care coordination, intense case management, transitional care services and medical management of Health Home recipients. The Health Homes will continue to operate under the 1932a authority and Section 2703 of the Patient Protections and the Affordable Care Act.

The State will continue its goals of the original SPA to coordinate with providers in the region and ensure that best practices are being followed in relation to management of chronic diseases; provide care management for health home recipients who are unstable to improve the management of chronic disease or other populations identified by Medicaid; facilitate care between primary care providers and the certified CMHCs, Substance Abuse (SA) providers, or other behavioral health providers for Health Home recipients; and implement initiatives to address Health Home Core Measures.

The Team of Health Care Professionals to provide these services include Physicians, Nurse Care Coordinators, Social Workers, Behavioral Health Professionals, Substance Abuse Providers, ADPH, CMHCs, FQHCs, RHCs, and Pharmacists.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$ 15191733.00
Second Year	2016	$ 31720188.00

Federal Statute/Regulation Citation

Affordable Care Act of 2010, Section 2703

Governor's Office Review

- ( ) **No comment.**
- ( ) **Comments received.**
  Describe:
- ( ) **No response within 45 days.**
- (•) **Other.**
  Describe:
  Governor's designee on file via letter with CMS.

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date:

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date: 03-04-15
Attachment 3.1-H Page Number: 2

Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ( ) **Public notice was not required and comment was not solicited**
- ( ) **Public notice was not required, but comment was solicited**
- (•) **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

- [ ] **Newspaper Announcement**
- [x] **Publication in State's administrative record, in accordance with the administrative procedures requirements.**
  Date of Publication:
  08/29/2014 (mm/dd/yyyy)
- [ ] **Email to Electronic Mailing List or Similar Mechanism.**
  Date of Email or other electronic notification:

(mm/dd/yyyy)

Description:

☐ **Website Notice**

Select the type of website:

☐ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date:

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date: 03-04-15
Attachment 3.1-H Page Number: 3

Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	
Name of Indian Tribe: Porch Creek Indian Tribe Date of consultation: 01/02/2014 (mm/dd/yyyy) Method/Location of consultation: A letter was sent by certified mail and by e mail requesting comments within 30 days of receipt of letter. No comments were received.	

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date: 03-04-15

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date: 03-04-15
Attachment 3.1-H Page Number: 4

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 09/10/2014 (mm/dd/yyyy)	

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date:

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date:
Attachment 3.1-H Page Number: 5

Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☑ **Two or more chronic conditions**

Specify the conditions included:

☑ **Mental Health Condition**
☑ **Substance Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☑ **BMI over 25**

Other Chronic Conditions	
Cancer	
Cardiovascular Disease	
Chronic Obstructive Pulmonary Disease	
Hepatitis C Virus	
HIV	
Sickle Cell Anemia	
Transplants	

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

☑ **Mental Health Condition**
☑ **Substance Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☑ **BMI over 25**

Other Chronic Conditions	

Specify the criteria for at risk of developing another chronic condition:
Alabama will identify individuals with a chronic condition on a monthly basis through analysis of Medicaid claims data for the previous 18 months. However, Transplants will be identified with a look back of Medicaid claims data for five years rather than 18 months. HIV will have a look back of Medicaid claims data of 18 months on the basis for identification medications. In addition, the PMP or local hospital may refer a patient for enrollment.

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

Individuals with a Serious and Persistent Mental Health Condition (SPMH) and Mental Health Condition include mental diseases or mental disorders, such as various psychiatric conditions, usually characterized by impairment of an individual's normal cognitive, emotional, or behavioral functioning, and caused by physiological or psychosocial factors. Diagnoses include schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, attention deficit disorders (ADD/ADHD) and other disorders of childhood or adolescents. Analysis of the Medicaid claims data will be reviewed monthly with a look back to the previous 18 months.

Individuals with SPMH, a mental health condition or a substance use disorder (SA) will be identified based on claims/payment data from Medicaid and/or the Alabama Department of Mental Health (ADMH). Analysis of the Medicaid claims/ADMH payment data will be reviewed monthly with a look back to the previous 18 months. The Executive Director or his/her Quality Care Manager of the Health Home review lists with the Community Mental Health Centers (CMHCs) and SA providers to identify individuals who could benefit from care management and support. State contracts with PMPs and Health Homes for the Patient 1st Program require PMPs and Health Homes to integrate bi-directional access and referrals between CMHCs and SA Providers, and the PMPs and Health Homes.

Geographic Limitations

☑ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.
July 1, 2012: Tuscaloosa, Fayette, Pickens, Greene, Hale, Sumter, Lamar, Bibb, Lee, Chambers, Tallapoosa, Coosa, Bullock, Russell, Macon, Limestone, Morgan, Cullman, Madison, Washington and Mobile Counties
April 1, 2015: Colbert, Franklin, Jackson, Lauderdale, Lawrence, Marshall, Blount, Calhoun, Cherokee, Chilton, Clay, Cleburne, Dekalb, Etowah, Jefferson, Randolph, St. Clair, Shelby, Talladega, Walker Choctaw, Marengo, Marion, Perry, Winston, Autauga, Barbour, Butler, Coffee, Covington, Crenshaw, Dale, Dallas, Elmore, Geneva, Henry, Houston, Lowndes, Montgomery, Pike, Wilcox, Baldwin, Clarke, Conecuh, Escambia, and Monroe Counties

If no, specify the geographic limitations:

○ **By county**

Specify which counties:

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

Other geographic area

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

Opt-In to Health Homes provider

Describe the process used:
Individuals eligible for health home services have the option to select amongst the Patient 1st Primary Medicaid Providers (PMPs), who are the state's designated PMPs and provide the comprehensive care management. Upon selection of the Patient 1st PMP, the eligible individual will be assigned to the Health Home to which the PMP has a contract. Individuals eligible for health home services have the option to select amongst the Patient 1st PMPs and may change providers at any time. Under the provisions of the SPA, enrollment into Patient 1st for purposes of the Health Home services is voluntary.

In addition to the Health Homes, who can serve all individuals with chronic conditions, the local CMHC is the designated provider for individuals who are eligible for Health Homes services based on a mental health (MH) designation, while the SA provider is the designated Health Home provider based on an SA designation. Individuals with a MH condition will be assigned a care manager from the CMHC when appropriate, but may choose to change care managers within the CMHC. Individuals with an SA condition will be assigned a care manager from the SA Provider when appropriate, but may choose to change care managers within the SA Providers.
Health Homes must provide and maintain on file documentation that an enrollee has consented to participate in a Health Home.

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:

The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.

Other

Describe:

The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date: 03-04-15
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Health Homes Providers

Types of Health Homes Providers

☐ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☑ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☑ **Physicians**

Describe the Provider Qualifications and Standards:

- PMPs must have contracts with the Alabama Medicaid Agency (AMA) and sign agreements with Health Homes addressing core competencies;
- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home

services;
• Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
• Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
• Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
• Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
• Coordinate and provide access to long-term care supports and services;
• Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
• Demonstrate a capacity to use health information technology (HIT)to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
• Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

☑ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:
Nurse Care Coordinators will be utilized in care coordination, transitional care and quality care. They must have a minimum of a BSN degree and maintain a current license.
• Must ensure that care is person-centered, culturally competent and linguistically capable;
• Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services;
• Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
• Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
• Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
• Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
• Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
• Coordinate and provide access to long-term care supports and services;
• Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☑ **Social Workers**

Describe the Provider Qualifications and Standards:
Social Workers are utilized in care coordination and quality care. They must have at a minimum a Bachelor's degree in Social Work from an accredited school of social work and maintain a current license.
Must ensure that care is person-centered, culturally competent and linguistically capable;
• Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services;
• Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
• Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
• Coordinate and provide access to comprehensive care management, care coordination, and transitional care across

settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
• Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
• Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
• Coordinate and provide access to long-term care supports and services;
• Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;

☑ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:
Behavioral Health Nurses musthave a minimum of a BSN degree, maintain a current license, have experience in the behavioral health field and the following:
• Must ensure that care is person-centered, culturally competent and linguistically capable;
• Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services;
• Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
• Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
• Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
• Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
• Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
• Coordinate and provide access to long-term care supports and services;
• Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;

☑ **Other (Specify)**

Provider	
Name: Alabama Department of Public Health (ADPH) Provider Qualifications and Standards: • ADPH must meet all state qualifications; • Sign a contract with AMA and be assigned a Medicaid Provider ID. Staff are required to have documented work experience with the population, an administrative capacity to insure quality of services in accordance with state and federal requirements, a functional financial management system that provides documentation of services and costs, capacity to document and maintain individual case records in accordance with state and federal requirements, demonstrated ability to assure a referral process consistent with Section 1092a(23) of the Social Security Act, allow freedom of choice of provider within their organization, and have a demonstrated capacity to meet the care management service needs of the target population they are serving; • Individual care managers must have a minimum of a BSN or Bachelor's Degree in Social Work and appropriate license.	
Name: Community Mental Health Centers Provider Qualifications and Standards: • CMHCs must be certified by the Alabama Department of Mental Health (ADMH) • Meet all state qualifications; • Sign a contract with AMA and be assigned a Medicaid Provider ID. Staff are required to have documented work experience with the population, an administrative capacity to insure quality of services in accordance with state and federal requirements, a functional financial management system that provides documentation of services and costs, capacity to document and maintain individual case records in accordance with state and federal requirements, demonstrated ability to assure a referral process consistent with Section 1092a(23) of the Social Security Act, allow freedom of choice of provider within their	

Provider	
organization, and have a demonstrated capacity to meet the care management service needs of the target population they are serving; • Individual care managers must have a minimum of a BSN or Bachelor's Degree in Social Work and appropriate license.	
Name: Federal Qualified Health Centers (FQHCs) Provider Qualifications and Standards: • FQHCs must meet all state and federal qualifications • Sign agreements with the Health Homes that address core competencies. • Must ensure that care is person-centered, culturally competent and linguistically capable; • Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; • Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; • Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families; • Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services; Coordinate and provide access to long-term care supports and services; • Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services; • Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and • Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.	
Name: Pharmacists Provider Qualifications and Standards: A Clinical Pharmacist must have a minimum of a Pharm.D. Degree and formal residency training or equivalent clinical experience (minimum of three calendar years) to work in concert with the Health Home leadership. A Network Pharmacist must have a current Alabama Pharmacy license in good standing.	
Name: Rural Health Clinics (RHCs) Provider Qualifications and Standards: • RHCs must meet all state and federal qualifications; • Sign agreements with the Health Homes that address core competencies; • Must ensure that care is person-centered, culturally competent and linguistically capable; • Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; • Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; • Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings • Coordinate and provide access to chronic disease management, including self-management support to individuals and their families; • Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services; • Coordinate and provide access to long-term care supports and services; • Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services; • Demonstrate a capacity to use HIT to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide	

Provider	
feedback to practices, as feasible and appropriate; and • Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.	
Name: Substance Abuse (SA) Providers Provider Qualifications and Standards: • SA Providers must be certified by the Alabama Department of Mental Health (ADMH); • Meet all state qualifications; • Sign a contract with AMA and be assigned a Medicaid Provider ID; • Staff are required to have documented work experience with the population, an administrative capacity to insure quality of services in accordance with state and federal requirements, a functional financial management system that provides documentation of services and costs, capacity to document and maintain individual case records in accordance with state and federal requirements, demonstrated ability to assure a referral process consistent with Section 1092a(23) of the Social Security Act, allow freedom of choice of provider within their organization, and have a demonstrated capacity to meet the care management service needs of the target population they are serving; • Individual care managers must have a minimum of a BSN or Bachelor's Degree in Social Work and appropriate license.	

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**

5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

Health Home Providers are required to have a documented work experience with the target population; an administrative capacity to insure quality of services in accordance with state and federal requirements; capacity to document and maintain individual case records in accordance with state and federal requirements; demonstrated ability to assure a referral process consistent with Section 1902a(23) of the Social Security Act; allow for free choice of provider; and demonstrated capacity to meet the care management service needs of the target population they are serving. Additionally, Health Homes are required to have an identified member of the team with behavioral health knowledge/expertise to work with the local CMHC and SA providers and include them in their management meetings.

Health Homes will continue the care coordination and transitional care program of qualified staff to meet the needs of patients with chronic conditions to improve medical management, transition from an inpatient or residential setting to the community, and integrate medical and behavioral health care. A person-centered, holistic care plan is developed and integrates all clinical and non-clinical health-care related needs and services.

Health Homes must use information technology systems and processes to integrate and share elements such as demographic data, enrollment data, assessment results, care plans, case notes, claims and pharmacy data. This system must be linked to other databases, systems and the centralized Health Home recipient record that the Health Home uses to maintain information about the recipient. The goal is to integrate the recipient's information in a meaningful way to facilitate care coordination.

In order to ensure the delivery of quality health home services, the Alabama Medicaid Agency (AMA) provides state learning activities for health home providers through regularly scheduled meetings.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

Attachment: "Alabama Health Home Care Coordination Model" explains the process for recipients receiving health home services.

The Health Home Services in Alabama are provided by a team of health care professionals from different agencies and health care providers to assure that Health Home recipients are receiving the six core elements of Health Homes. The lead Health Home Entity, currently called Patient Care Network of Alabama coordinates these services to assure that patients are identified and services are provided without duplication. This organization contracts with PMPs as part of the team, and has developed a relationship with FQHCs, RHCs, ADPH, and CMHCs in order to fulfill these goals. The Health Home Entity receives a PMPM for their coordination of these services, leading the medical management/ quality improvement initiatives of the team of health care professionals, as well as care coordination and transitional care services. Staff hired by the lead Health Home Entity to provide services under this PMPM rate include social workers, nurses, pharmacists, and a medical director. The Health Home Entity does not pay a fee to any organization, agency, or PMP for services.

Eligible Team of Health Care Professionals include: Categories of physicians that are authorized under the Alabama Medicaid State Plan as PMP include physicians, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). PMPs have direct responsibility to provide comprehensive care management services in coordination with a team of health care professionals who provide the care coordination under the SPA. "Eligible Team of Health Care Professionals" authorized to provide care coordination under SPA include Health Home Care Coordinators, ADPH, and ADMH contracted CMHCs and SA providers. Health Home staff include a medical director, pharmacist, and a nurse or social work care coordinator.

Health Homes are required to have an identified member of their team with behavioral health knowledge/expertise to work with the local CMHC and SA provider and include them in their management meetings. PMPs and Health homes are contractually required to partner with CMHCs.

Services provided by the Health Homes include:
• Comprehensive Care Management: PMPs, which include physicians, FQHCs, and RHCs will provide comprehensive care management by identifying high-risk individuals with chronic conditions and/or a mental health condition to refer for transitional care, care coordination, or other needed services to manage their conditions; outreach services to plan and communicate with other primary specialty care providers regarding patient's care; develop a comprehensive health plan informed by the patient, which integrates care across various systems (MH/SA/Primary Care); and clarify and communicate the patient's preferences to all involved providers while assuring timely delivery of services.
• Care Coordination: Care Coordination services are provided by Nurse or Social Work Care Coordinators and Behavioral Health Nurses employed by Health Homes, Community Mental Health Centers (CMHC), or Alabama Department of Public Health (ADPH). Health Home recipients identified with MH/SA diagnoses, or with public health needs receive care coordination from the appropriate agencies. The recipient may change care coordinators by choice at any time within the CMHC, ADPH, or Health Home to best serve their needs. Care coordination is an enrollee-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan developed, and services managed, monitored and reassessed as needed by an identified care coordinator following evidence-based standards of care to the degree possible. In addition to the core elements of care coordination, the care coordinator provides disease management education, medication reconciliation, facilitation of sub-specialty referrals, transitional care interventions, works to ensure appropriate level of care is being provided and unnecessary emergency department visits are avoided, as well as providing education to patients about the importance of a medical home.
• Health Promotion: Health promotion is considered a key component in managing chronic diseases and is provided by the team of Health Care Professionals including physicians, FQHCs, RHCs, Social Workers, Nurses, Behavioral Health, Pharmacists, and Public Health. Information is provided to the health home recipient and reinforced through care management, care coordination, and transitional care in order to prevent adverse outcomes.
• Comprehensive transitional care/ follow-up: Comprehensive transitional care is led by a transitional care nurse or behavioral health nurse, but may include a multidisciplinary team of physicians, social workers, and pharmacists to assist the recipient in safe transitioning of care to the next most appropriate level including movement from inpatient to a nursing facility or home setting. Health home recipients are identified through claims or inpatient facilities and screened for services. The transitional care nurse or team explains health home services to the recipient. If the patient chooses to receive transitional care services, an assessment of the patient's health and psychosocial needs is completed and a care plan developed in order to assist the patient in transitioning to a new level of care. Follow up services are provided in the home or new residential setting by the appropriate health care team member. Care Coordination services may begin simultaneously or following the transitional care services depending on the recipient's needs.
• Patient and family support: Services are provided by all health care team members to provide the patient and family with needed education, information, and resources in order to better manage their chronic conditions.
• Referral to community and social support services: The PMPs, social workers, and nurses identify needs of the patients through their assessments and refer to needed services based on those needs.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
The Alabama Health Home model of service delivery will operate under a "whole-person" approach to care within a culture of continuous quality improvement that looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being. Providers of Health Home services will use a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical care needs of an individual. Members of the "Health Home Team of Health Care Professionals":
1. Must be registered with the State, required to meet state qualifications, and have been provided a state assigned Medicaid Provider ID;
2. Must ensure that care is person-centered, culturally competent and linguistically capable;
3. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
4. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
5. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
6. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
7. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
8. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;

9. Coordinate and provide access to long-term care supports and services;
10. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non -clinical health-care related needs and services;
11. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
12. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
PMPs and Health Home: The following Alabama standards, which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the State and the Patient 1st PMP and Health Home, and in the contract between the Health Home and their providers. PMPs and Health Homes must sign agreements with the State and each other. Alabama standards may be amended as necessary and appropriate. Standards include:
1. Capacity to provide access to care that includes an in-person, afterhours and telephone. The PMP must provide voice-to-voice access to medical advice and care for enrollees 24 hours a day 7 days a week.
2. Ability to provide comprehensive whole person care that includes a comprehensive health care assessment (including mental health and substance use), coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders, medical and health care services informed by evidence-based clinical practice guidelines, mental health, substance abuse, and developmental services, and chronic disease management, including self-management support to individuals and their families, and interventions.
3. Ability to provide continuous personal clinician assignment and clinician care, organization of clinical information, clinical information exchange and specialized care settings.
4. Capability to coordinate and integrate that includes a capacity for population data management; to use health information technology (HIT); to develop a comprehensive health plan for each individual that coordinates and integrates clinical and non-clinical health-care related needs and services; for test and result tracking; to coordinate and provide access to Health Homes and provide comprehensive care management (PMPs), care management (Health Homes), and transitional care across settings (Health Homes and PMPs), and to coordinate and provide access to long-term care supports and services and end of life planning.
5. Capacity to provide culturally appropriate, and person-and family-centered health home services, coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services, and provide a positive experience of care.
Contract Requirements:
1. PMPs must have contracts with AMA and the local Health Home. PMPs must sign agreements that address core competencies. Integration and coordination of services for individuals with MH and/or SA shall be addressed in all contracts (PMP and Health Home), including the requirement for ongoing processes with community providers and other community agencies to coordinate the planning and provision of care management. Alabama standards, which may be met onsite or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the State and Patient 1st PMP and the Health Home and in the contract between the Patient 1st, Health Home and their providers. PMPs and Health Homes must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate.
2. Health Homes must sign agreements that address core competencies. Integration and coordination of services for individuals with MH and/or SA is addressed in all contracts, including the requirement for ongoing processes with CMHCs and other community agencies to coordinate the planning and provision of care management. In addition, the Health Home team must include a care coordinator with expertise and/or knowledge in behavioral health who will serve as a liaison between the PMP and the CMHC and or SA provider.
3. The CMHC will complete behavioral health screening (non-standardized) for Health Home recipients with substance use diagnoses and determines if individual is eligible for care management through the ADMH SA care management provider. If not eligible, the individual is referred back to the PMP. If the recipient is determined to be “unstable”, the Health Home is notified and the individual becomes eligible for care management services through the Health Home.
4. The ADPH provider completes screening (non-standardized) and determines if the individual is eligible for care management through ADPH Care management provider. If not eligible, the individual is referred back to the PMP. If “unstable”, the Health Home is notified and the individual becomes eligible for care management services through the Health Home.

Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☑ **Fee for Service**
☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☑ **Fee for Service Rates based on:**

☑ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

Some Health Home Recipients receive care coordination services through ADMH or ADPH based on their condition and needs, such as behavioral health, substance use disorders, or issues related to public health. Since this is only a portion of the Health Home population, these providers are paid on a Fee for Service basis through AMA.

The Payment System for services for the Health Homes in Alabama:

Health Homes (Lead Entity): PMPM of $9.50 monthly from AMA to coordinate services provided by the Team of Health Care Professionals to assure all six core services are provided, lead medical management meetings and Quality Initiatives, and provide care coordination and transitional care services.
Private PMPs: PMPM of $8.50 monthly from AMA to coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support

services. Care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

FQHCs: No additional payment provided. The Providers at FQHCs coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. The more intensive, health home level of care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

RHCs: No payment provided at this time. The Providers at RHCs coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. The more intensive, health home level of care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

ADPH: AMA directly pays Fee for Service on a fee schedule to provide Care Coordination Services to Health Home recipients by nurses and social workers.

CMHCs: AMA directly pays Fee for Service on a fee schedule to provide Care Coordination Services to Health recipients by nurses and social workers.

All Health Home team members will be covered by the PMPM rate described in the Payment Methodology section with the exception of the FQHCs and RHCs. Their current reimbursement under the prospective payment system includes compensation for management of those populations who meet the definition of a chronic health condition. ADPH and ADMH will be reimbursed for health homes services when one of them serves as a care coordination provider.

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable

unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.
Private PMPs are provided a monthly payment of $8.50 if the following requirements are met:
1. The person is identified as meeting Health Home eligibility criteria on the State's MMIS and in the Care Management Information System;
2. The person is enrolled as a Health Home member at the PMP; and
3. 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 Health Home on a monthly basis reports by individual that indicate potential gaps in service delivery. The Health Home 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).

The Payment System for services for the Health Homes in Alabama:

Health Homes (Lead Entity): PMPM of $9.50 monthly from AMA to coordinate services provided by the Team of Health Care Professionals to assure all six core services are provided, lead medical management meetings and Quality Initiatives, and provide care coordination and transitional care services.
Private PMPs: PMPM of $8.50 monthly from AMA to coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. Care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

FQHCs: No additional payment provided. The Providers at FQHCs coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. The more intensive, health home level of care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

RHCs: No payment provided at this time. The Providers at RHCs coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. The more intensive, health home level of care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

ADPH: AMA directly pays Fee for Service on a fee schedule to provide Care Coordination Services to Health Home recipients by nurses and social workers.

CMHCs: AMA directly pays Fee for Service on a fee schedule to provide Care Coordination Services to Health recipients by nurses and social workers.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
Alabama has taken care to ensure the reimbursement model is designed to only fund Health Home Services that are not covered by any of the currently available Medicaid funding mechanisms.

Through the screening assessment process with the enrollees, Health Home staff determine if similar services are being provided under othe Medicaid authorities in order to prevent duplication of services.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:
PMPs will provide comprehensive care management to all Health Home eligible by:
1. Identifying high-risk individuals (in addition to the efforts by the state directly to identify high-risk enrollees);
2. Outreach to, plan and communicate with other primary and specialty care providers regarding a patient's care;
3. Developing a comprehensive health plan informed by the patient, which integrates care across various systems (MH/SA/Primary Care); and
4. Clarifying and communicating the patient's preferences to all involved providers while assuring timely delivery of services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The state currently requires an integrated medical record but not an electronic continuity of care record. When national standards are finalized, One Health Record will use a standardized CCD. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (EHR) for transport of information through the One Health Record. In addition, in order to receive EHR Incentive Payments for meaningful use, providers will need to connect to One Health Record. Thus, One Health Record will become the "norm" for the exchange of health information in Alabama.

In the interim, the state approves web-based tools, such as web-based application, that facilitates the efficient exchange of medical information between physician offices and healthcare facilities. The use of the process is not required, but can take the place of the written referral. The state currently contracts with the University of South Alabama (USA) Center for Strategic Health Innovations (CSHI) to support Patient 1st through a web-based secure management system called Real Time Medical Electronic Data Exchange (RMEDE). Based on Medicaid's paid claims information, the care management system provides a foundation for practice improvement by providing timely reports on select clinical measures that can be addressed with patients through targeted interventions. An Interactive Voice Response (IVR) system allows Patient 1st Health Home patients with chronic diseases to transmit home monitoring information into a care management tool to track and impact key health indicators of their patients with Congestive Heart Failure, Hypertension, and Diabetes.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians serve as the PMP in the Medical Home and coordinate the care of the patient by developing a person-centered treatment plan that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services, including access to care coordination and transitional care across settings.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Care Coordination

Definition:
Care Coordination is a enrollee-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan developed, and services managed, monitored and reassessed as needed by an identified care coordinator following evidence-based standards of care to the degree possible. In addition to the core elements of care coordination/care management, the care coordinator provides disease management education, medication reconciliation, facilitation of sub-specialty referrals, transitional care interventions, works to ensure appropriate level of care is being provided and unnecessary emergency department visits are avoided, as well as providing education to patients about the importance of a medical home.

The Health Home Care Coordinator, a member of the Health Home team, provides care management, serves as

a liaison between the family, PMP, other care managers, and Medicaid. Care coordination is assured through care plans that are developed using a team approach. The care plans must have the capacity to accommodate participants with multiple diseases and co-morbidities. The individualized care plan identifies the enrollee, enrollee's caregiver, enrollee's Health Home, specialists and other ancillary providers involved in the participant's care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The state currently requires an integrated medical record but not an electronic continuity of care record. When national standards are finalized, One Health Record will use a standardized CCD. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (EHR) for transport of information through the One Health Record. In addition, in order to receive EHR Incentive Payments for meaningful use, providers will need to connect to One Health Record. Thus, One Health Record will become the "norm" for the exchange of health information in Alabama.

In the interim, the state approves web-based tools, such as web-based application, that facilitates the efficient exchange of medical information between physician offices and healthcare facilities. The use of the process is not required, but can take the place of the written referral. The state currently contracts with the University of South Alabama (USA) Center for Strategic Health Innovations (CSHI) to support Patient 1st through a web-based secure management system called Real Time Medical Electronic Data Exchange (RMEDE). Based on Medicaid's paid claims information, the care management system provides a foundation for practice improvement by providing timely reports on select clinical measures that can be addressed with patients through targeted interventions. An Interactive Voice Response (IVR) system allows Patient 1st Health Home patients with chronic diseases to transmit home monitoring information into a care management tool to track and impact key health indicators of their patients with Congestive Heart Failure, Hypertension, and Diabetes.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
1. Screening for clinical depression.
2. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
3. Coordination and access to mental health and substance abuse services.
4. Facilitate communication and coordination between members of the health care team and involving the individual in the decision-making process in order to minimize fragmentation in services.

☑ **Nurse Care Coordinators**

Description
1. Development of a comprehensive health plan (individualized care plan) that is person centered for each individual and coordinates and integrates all of the individual's clinical and non-clinical health care related needs and services. Development of the comprehensive health plan is collaborative with the enrollee and family or caregiver and using a team approach. The comprehensive health plans must have the capacity to accommodate individuals with multiple diseases and co-morbidities. The comprehensive health plan identifies the individual, caregiver, Health Home, specialists and other ancillary providers involved in the participant's care;
2. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
3. Coordination and access to mental health and substance abuse services;
4. Coordination and access to long-term care supports and services;
5. Management, monitoring and reassessment of an individual as needed by an identified care coordinator following evidence-based standards of care and enrollee-centered, assessment –based interdisciplinary approach to integrating health care and social support services;
6. Traditional case management services through public health, including assistance with understanding program requirements, helping with transportation needs, and assessment of the home environment and factors that may prevent the patient from being compliant with medical care protocols. It also includes mental health, substance abuse and child health issues such as

understanding the need for preventive care, i.e. immunizations, etc.;
7. Screening for clinical depression;

8. Disease management education, medication reconciliation, facilitation of sub-specialty referrals and transitional care interventions;
fragmentation in services;
9. Assistant to the individual in the safe transitioning of care to the next most appropriate level.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
1. Development of a comprehensive health plan (individualized care plan) that is person centered for each individual and coordinates and integrates all of the individual's clinical and non-clinical health care related needs and services. Development of the comprehensive health plan is collaborative with the enrollee and family or caregiver and using a team approach. The comprehensive health plans must have the capacity to accommodate individuals with multiple

diseases and co-morbidities. The comprehensive health plan identifies the individual, caregiver, Health Home, specialists and other ancillary providers involved in the participant's care;
2. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
3. Coordination and access to mental health and substance abuse services;
4. Coordination and access to long-term care supports and services;
5. Management, monitoring and reassessment of an individual as needed by an identified care coordinator following evidence-based standards of care and enrollee-centered, assessment –based interdisciplinary approach to integrating health care and social support services;
6. Traditional case management services through public health, including assistance with understanding program requirements, helping with transportation needs, and assessment of the home environment and factors that may prevent the patient from being compliant with medical care protocols. It also includes mental health, substance abuse and child health issues such as understanding the need for preventive care, i.e. immunizations, etc.;
7. Screening for clinical depression;

8. Disease management education, medication reconciliation, facilitation of sub-specialty referrals and transitional care interventions;
fragmentation in services;
9. Assistant to the individual in the safe transitioning of care to the next most appropriate level.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Promotion

Definition:
Health Home staff, through Care Coordinators, Behavioral Health Nurses, and Transitional Care Nurses provide disease management education, utilization of services, and the importance of a medical home.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The state currently requires an integrated medical record but not an electronic continuity of care record. When national standards are finalized, One Health Record will use a standardized CCD. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (EHR) for transport of information through the One Health Record. In addition, in order to receive EHR Incentive Payments for meaningful use, providers will need to connect to One Health Record. Thus, One Health Record will become the "norm" for the exchange of health information in Alabama.

In the interim, the state approves web-based tools, such as web-based application, that facilitates the efficient exchange of medical information between physician offices and healthcare facilities. The use of the process is not required, but can take the place of the written referral. The state currently contracts with the University of South Alabama (USA) Center for Strategic Health Innovations (CSHI) to support Patient 1st through a web-based secure management system called Real Time Medical Electronic Data Exchange (RMEDE). Based on Medicaid's paid claims information, the care management system provides a foundation for practice improvement by providing timely reports on select clinical measures that can be addressed with patients through targeted interventions.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
1. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
2. Disease management education.
3. Encouragement of the appropriate use of health care services to improve quality of care and maintain cost effectiveness.
4. Adhering to Early and Periodic Screening, Diagnosis, and treatment (EPSDT) requirements.
5. Providing health-promoting lifestyle interventions, such as substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.
6. Support health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
7. Promoting evidence based wellness and prevention by linking Health Home recipients with resources for smoking cessation, diabetes, asthma and other services based on individual needs and preferences.

☑ **Nurse Care Coordinators**

Description
1. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
2. Disease management education.

3. Encouragement of the appropriate use of health care services to improve quality of care and maintain cost effectiveness.
4. Adhering to Early and Periodic Screening, Diagnosis, and treatment (EPSDT) requirements.
5. Providing health-promoting lifestyle interventions, such as substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.
6. Support health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
7. Promoting evidence based wellness and prevention by linking Health Home recipients with resources for smoking cessation, diabetes, asthma and other services based on individual needs and preferences.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

1. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
2. Disease management education.
3. Encouragement of the appropriate use of health care services to improve quality of care and maintain cost effectiveness.
4. Adhering to Early and Periodic Screening, Diagnosis, and treatment (EPSDT) requirements.
5. Providing health-promoting lifestyle interventions, such as substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.
6. Support health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
7. Promoting evidence based wellness and prevention by linking Health Home recipients with resources for smoking cessation, diabetes, asthma and other services based on individual needs and preferences.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
AMA requires that PMPs, and Health Home Care Coordinators, who are social workers or nurses, assist the enrollee in the safe transitioning of care to the next most appropriate level including movement from inpatient to a nursing facility or home setting. PMPs and Health Home Care Coordinators must sign agreements that address core competencies and require the establishment of an ongoing process with community providers and other community agencies to coordinate the planning and provision of care management and other support services for enrollees needing those services. Hospitals have had an ongoing voluntary working relationship with their local Health Homes, but have a bigger incentive to work with the PMPs and PCNAs to arrange appropriate follow-up in order to avoid hospital readmission penalties.
Medicaid enrollees who meet the criteria will be identified through claims, thus the Health Home Care Coordinators and PMP is not dependent on the hospital for identification. There are no formal MOUs, but the state requirements of health home providers are such that they are aware when someone goes into the hospital. The Health Home Care Coordinators have a working relationship with all hospitals in their geographic area. In addition, the Health Home team will include an individual with knowledge/expertise in MH/ SA. Alabama standards, which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the state and Patient 1st PMP and Health Home and in the contract between the Patient 1st Health Home and their providers. PMPs and the Health Home must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate.

Provider Types Furnishing the Service: PMPs, Health Home Care Coordinators

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The state currently requires an integrated medical record but not an electronic continuity of care record. When national standards are finalized, One Health Record will use a standardized CCD. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (EHR) for transport of information through the One Health Record. In addition, in order to receive EHR Incentive Payments for meaningful use, providers will need to connect to One Health Record. Thus, One Health Record will become the “norm” for the exchange of health information in Alabama.

In the interim, the state approves web-based tools, such as web-based application, that facilitates the efficient exchange of medical information between physician offices and healthcare facilities. The use of the process is not required, but can take the place of the written referral. The state currently contracts with the University of South Alabama (USA) Center for Strategic Health Innovations (CSHI) to support Patient 1st through a web-based secure management system called Real Time Medical Electronic Data Exchange (RMEDE). Based on Medicaid’s paid claims information, the care management system provides a foundation for practice improvement by providing timely reports on select clinical measures that can be addressed with patients through targeted interventions. An Interactive Voice Response (IVR) system allows Patient 1st Health Home patients

with chronic diseases to transmit home monitoring information into a care management tool to track and impact key health indicators of their patients with Congestive Heart Failure, Hypertension, and Diabetes.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Health Home Care Coordinators with Behavioral Health experience to assist with transitioning of patients from residential or inpatient behavioral health facilities to the community.

☑ **Nurse Care Coordinators**

Description
Health Home Nurse Care Coordinators to assist patients with transitioning from an inpatient setting to the community. These Transitional Nurse Care Coordinators identify patients in an inpatient setting, screen for eligibility, explain services, assist with discharge planning, and complete home visits to patients as follow up for needs.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians (PMPs) develop care plans for medical needs for the patient and refer to needed agencies and DME services to assist with patient's transition to the community.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Social Work Care Coordinators are utilized to explain services in the inpatient setting, assess for psychosocial needs, and refer to community agencies and resources to assist patient with transition back to the community.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

Definition:
Activities within the scope of patient and family support (including authorized representatives):
• Alabama requires PMPs to provide patient and family support as appropriate. PMPs must educate and empower the enrollee and the family or caregiver about treatment options, community resources, insurance benefits, psychosocial concerns, and care management, so that timely and informed decisions can be made.
• Alabama requires health home care management providers Health Home, CMHCs, SA providers and ADPH) to provide patient and family support as appropriate.
• Alabama specifically requires the PMPs and Health Home Care Coordinators to advocate for both the state and the enrollee to facilitate positive outcomes for the enrollee and where a conflict arises to prioritize the needs of the enrollee.

Provider Type: PMPs, Health Home Care Coordinators, CMHCs, SA Providers, and ADPH

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The state currently requires an integrated medical record but not an electronic continuity of care record. When national standards are finalized, One Health Record will use a standardized CCD. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (EHR) for transport of information through the One Health Record. In addition, in order to receive EHR Incentive Payments for meaningful use, providers will need to connect to One Health Record. Thus, One Health Record will become the "norm" for the exchange of health information in Alabama.

In the interim, the state approves web-based tools, such as web-based application, that facilitates the efficient exchange of medical information between physician offices and healthcare facilities. The use of the process is not required, but can take the place of the written referral. The state currently contracts with the University of South Alabama (USA) Center for Strategic Health Innovations (CSHI) to support Patient 1st through a web-based secure management system called Real Time Medical Electronic Data Exchange (RMEDE). Based on Medicaid's paid claims information, the care management system provides a foundation for practice improvement by providing timely reports on select clinical measures that can be addressed with patients through targeted interventions.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Behavioral Health Specialists from the CMHCs, SA and the Health Homes (Care Coordinators) assist patients and families through education to the enrollee and family about treatment options, community resources, and linking to behavioral health care needs.

☑ **Nurse Care Coordinators**

Description
Nurse Care Coordinators in the Health Home (Health Home Care Coordinators) assist patients and families through education of the treatment plan, medical regime, treatement options; and empower the patient and family to be proactive in their care in order to have positive outcomes.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians (PMPs) provide patient and family support as needed through education and empowerment to the enrollee and famly about treatment options, community resources, insurance benefits, psychosocial concerns, and care management so that timely and informed decisions can be made.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Social Workers (Health Home Care Coordinators) provide patient and family support through addressing psychosocial concerns and education of community resources.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Referral to community and social support services, if relevant

Definition:
Activities within the scope for referral to community and social support services include:
• Where relevant and as appropriate, PMPs and Health Home Care Coordinators are specifically required to establish "an ongoing process with community providers and other community agencies to coordinate the planning and provision of care management and other support services for enrollees needing those services; however, all care management managers may engage in this activity for their specific population. Services include long term care services and support such as housing, home delivered meals, services for individuals with disabilities and adult care.
• For individuals with public health needs, the ADPH will take the lead to assure community and social support services relevant to public health and obtained through the public health infrastructure are available to health home services and enrollees. Since much of the public health infrastructure in Alabama is through the State, the ADPH will coordinate these efforts as a participant in the team.
• Health Homes are required to have a member of their team with expertise/knowledge in MH/SA to assure integration with CMHCs, SA providers and community resources

Provider Types: PMPs, Health Home Care Coordinators, CMHCs, SAs, and ADPH

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
The state currently requires an integrated medical record but not an electronic continuity of care record. When national standards are finalized, One Health Record will use a standardized CCD. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (EHR) for transport of information through the One Health Record. In addition, in order to receive EHR Incentive Payments for meaningful use, providers will need to connect to One Health Record. Thus, One Health Record will become the "norm" for the exchange of health information in Alabama.

In the interim, the state approves web-based tools, such as web-based application, that facilitates the efficient exchange of medical information between physician offices and healthcare facilities. The use of the process is not required, but can take the place of the written referral. The state currently contracts with the University of South Alabama (USA) Center for Strategic Health Innovations (CSHI) to support Patient 1st through a web-

based secure management system called Real Time Medical Electronic Data Exchange (RMEDE). Based on Medicaid's paid claims information, the care management system provides a foundation for practice improvement by providing timely reports on select clinical measures that can be addressed with patients through targeted interventions.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Behavioral Health Specialists from the Health Homes, SA and the CMHCs provide education as needed for community resources to enrollees and their families and link them to any needed behavioral health services.

☑ **Nurse Care Coordinators**

Description
Nurse Care Coordinators assist as needed with referrals to community resources.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians assist as needed to refer to community resources for the enrollee.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Social Work Care Coordinators assess for any psychosocial needs, educated the patient and family on community resources and agencies, and assist as needed for referrals.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

Patients are referred to Health Homes through inpatient settings, RMEDE, PMPs, or community agencies. Home Health recipients identified in an inpatient setting received transitional care through the Health Homes to assist in returning to a community based setting. Transitional care services include discharge planning, medication reconciliation, referrals to community resources, and education on the recipient's chronic condition and medical care. After the transition to the community, the Transitional Care nurse from the Health Home refers the patient to a Care manager for further assessment. All other Health Home recipients are assessed by the Care Manager after patient accepts services. The objectives of the Health Home Care Management Program are to:
a) Develop and implement patient centered holistic plans of care;
b) Improve health literacy, health outcomes and self-management'
c) Improve utilization of Information Technology resources by participants and providers in Health Home as available;
d) Promote effective use of the healthcare system and community resources;
e) Reduce the potential for risks of catastrophic or severe illness;
f) Prevent disease exacerbations and complications;
g) Reduce inappropriate utilization and costs associated with Emergency Department, and hospital inpatient services;
h) Work to identify additional key resources and incorporate these into the strategies implemented such as partnerships with ADPH and ADMH;
If an eligible Health Home recipient elects not to participate in a Health Home, the Care Manager or Transitional Care Nurse refers the recipient to any needed resources.
Health Home recipients are discharged once they no longer choose to participate.
See Attachment 3 for a flow chart of the Health Home Process.

☐ **Medically Needy eligibility groups**

- ○ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**
- ○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**
  - ○ **All Medically Needy receive the same services.**
  - ○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Description: For Health Home target members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days for each age, gender and total combination.

Measure Specification, including numerator and denominator: Age as of 12/31 of the measurement year by ages 18, 19, 20… up to age 85 and group everyone 85 and above together.
Numerator: The number of Index Hospital Stays with a readmission within 30 days for each age, gender and total combination.

Denominator: The number of Index Hospital Stays for each age, gender and total combination.
Frequency: Annual

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Data Source: Medicaid claims
Specification: Total cost per member per month (PMPM) will be tracked and calculated based on total cost all patients in the Health Home geographical region divided by Total Number Eligible. This is a state specific measure as there is no national measure to use and will be reported monthly per age (<1, 1-5, 6-18, >19) and by median PMPM for providers in region.
Pharmacy cost compared to inpatient and ER cost for targeted medications and diagnosis will also be calculated. The numerator is the total cost of preventative medication and the denominator is the total cost of ER and Inpatient Claims for targeted diagnosis based on Medicaid claims data. A second measure will compare the Patient 1st population with asthma diagnosis costs of all asthma medications to the cost of ER/hospital visits attributed to asthma-related I-CD9 code. The state will move to ICD-10 codes at the appropriate time.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
The Alabama health information exchange (HIE) initiative, One Health Record®, uses a standardized Continuity of Care Document (CCD) to share a summary of patient data. One Health Record is the gateway for individual or group entities (primary providers, pharmacies, EMTs, hospitals, clinics, organized health systems, payers, consumers for Personal Health Records and government institutions), within the state to connect with other state HIEs and Medicaid agencies, federal agencies, and exchange at the federal level. One Health Record® is part of Alabama's MMIS and will connect to other HIEs throughout Alabama and neighboring states.
The state currently requires an integrated medical record but not an electronic continuity of care record. Patient 1st Providers and Health Homes connected to One Health Record® will have the ability to push and consume a CCD through secure routing and a statewide provider directory. The exchange will enable the providers to pull summaries from disparate sources and create a holistic view of the patient's status and care.

The State currently contracts with the University of South Alabama (USA) Center for Strategic Health Innovations (CSHI) to support Patient 1st through a web-based secure management system called Real Time Medical Electronic Data Exchange (RMEDE). Based on Medicaid's paid claims information, the care management system provides a foundation for practice improvement by providing timely reports on select clinical measures that can be addressed with patients through targeted interventions. An Interactive Voice Response (IVR) system allows Patient 1st Health Home patients with chronic diseases to transmit home monitoring information into a care management tool to track and impact key health indicators of their patients with Congestive Heart Failure, Hypertension, and Diabetes.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

For Health Home Target members 18 years of age and older

Measure Specification, including a description of the numerator and denominator.
The number of acute inpatient stays during the mesurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Numerator: The number of Index Hospital Stays with a readmission within 30 days for each age, gendar, and total combination.

Denominator: The number of Index Hospital Stays for each age, gender, and total combination.

Specifications: Age as of 12/31 of the measurement year by ages 18, 19, 20....up to age 85 and group everyone 85 and above together.
Data Sources:
Medicaid Claims for acute care hospital
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:

Percentage of patients who have had a visit to an Emergency Department (ED)/ Urgent Care office for

Measure Specification, including a description of the numerator and denominator.
Specifications: Patients with a diagnosis of Asthma.

Numerator: The number patients from the denominator who have had a visit to an ED/ Urgent Care office for sthma in the past six months.

Denominator: Total number of patients with asthma who were eligible for Medicaid in the measurement year and in the reporting year.
Data Sources:
Medicaid Claims
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:

None at this time.

Measure Specification, including a description of the numerator and denominator.
n/a
Data Sources:
n/a
Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- **Annually**
- **Continuously**
- **Other**

n/a

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
Assess hospital admission rates by service (medical, surgical, maternity, mental health and chemical dependency), for acute care hospitals (non-psychiatric hospitals) in the participating health home geographic sites and remainder of state for the chronic conditions identified as eligible for health home services using Medicaid Claims (annual). MMIS claims data will be analyzed using current and new data warehouse and distributed via e-mail or disc distribution. Eligible population will be those 18 years of age and older, age as of 12/31 measurement year and the focus of the collection is the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

The state will utilize the quality process and outcome measures described in the SPA to assess quality improvements and clinical outcomes. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, the Health Home level, at the aggregate level for each geographic area, and for all participating health homes. For claims-based measures, the State will track change over time to assess whether statistically significant improvement has been achieved.

Chronic Disease Management
The state will assess the provision of chronic disease management by the PMPs and Networks for individuals with chronic conditions specified within the Health Home Core Set Measures through Medical Claims/Charts.

The care management system tracks referrals to social services and community and social support. One Health Record will provide the infrastructure for PMPs and Health Homes to also connect with state agencies, including Medicaid, ADPH, and ADMH and other health home providers who choose to connect to One Health Record through a state “gateway” that is now available. PMPs and Health Homes will be encouraged to utilize current HIT systems and connect to One Health Record to communicate with patients, family and caregivers in a culturally appropriate manner.

Alabama has established business and technical operational structures to comply with the evaluation reporting requirements including nature, extent, and use of the health home model of service delivery, assessment of program implementation processes and lessons, assessment of quality improvements and clinical outcomes and estimates of cost savings.

MMIS Data can be shared across the systems. It will be analyzed using the current and future state enterprise wide data repository/warehouse system along with other systems as they become available through One Health Record and Medicaid eligibility system enhancements. Chart review replacement will be considered once One Health Record is operational for a year to give all providers the opportunity to fully utilize their EHR systems.

Coordination of Care for Individuals with Chronic Conditions
The state will also assess the provision of care coordination services for individuals with chronic conditions specified within this State Plan Amendment based on the measurements presented earlier in this State Plan. The state has already put into place quality measure reporting requirements for health homes that apply to both the PMPs and the Health Homes, including the collection and reporting of data on patient outcomes and the collection of data on patient experience of care. MMIS claims data can be shared across the systems. It will be analyzed using the current and future state enterprise wide data repository/warehouse system along with other systems as they become more readily available through One Health Record and Medicaid eligibility system enhancements. Chart review replacement will be considered once One Health Record is operational for a year to give all providers opportunity to fully utilize their HER systems.

Assessment of Program Implementation
The State will monitor implementation through the evaluation process addressed in this State Plan. The Medicaid Agency is also working directly with ADPH, ADMH, etc. and meeting regularly regarding goals established in this State Plan and performance indicators provided elsewhere in this State Plan Amendment.
The State has adopted the Health Home Core Set Measures as defined by CMS. However, the State will be unable to measure the Control of High Blood Pressure and Care Transition – Timely Transmission of Transition Record until HIE is fully operational. Although health information capacity is not currently statewide, implementation has begun.

The State will setup business and technical operational structures to comply with the evaluation reporting requirements, including: nature, extent, and use of the health home model of service delivery, assessment of program implementation processes and lessons learned, assessment of quality improvements and clinical outcomes, and estimates of cost savings.
The State will monitor Health Home providers to ensure that Health Home services are being provided that meet the state's Health Home provider standards and CMS' Health Home core functional requirements. Oversight activities will include, but not be limited to contract management, clinical and claims data review and analysis, and other activities defined by the State for Medicaid program integrity and ongoing management.

Processes and Lessons Learned
The State will monitor implementation through the evaluation process addressed in this State Plan. The Medicaid Agency is also working directly with ADHR, ADMH, ADPH regarding goals and indicators provided in this State Plan Amendment. Federal requirements are provided in contracts between the State and the Health Homes, and the State and the PMPs.

Assessment of Quality Improvements and Clinical Outcomes
The State will utilize the quality process and outcomes measures described in the prior section to assess quality improvements and clinical outcomes based on the Health Home Core Set Measures. For registry-based, claims-based, and audit-based measures, assessment will occur both at the individual practice level, the Health Home level, at the aggregate level for each geographic area, and all participating Health Homes. For claims-based measures, the State will track change over time to assess whether statistically significant improvement has been achieved. The State has adopted the Health Home Core Set Measures as defined by CMS. However, the State will be unable to measure the Control of High Blood Pressure and Care Transition – Timely Transmission of Transition Record until HIE is fully operational. Although health information capacity is not currently statewide, implementation has begun.
The State will setup business and technical operational structures to comply with the evaluation reporting requirements, including: nature, extent, and use of the Health Home model of service delivery, assessment of program implementation processes and lessons learned, assessment of quality improvements and clinical outcomes, and estimates of cost savings.

Estimates of Cost Savings

☐ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.
The State will determine total Cost All Patients in the Region divided by Total Number Eligible reported monthly Per Age (<1, 1-5, 6-18, >19) and also report median PMPM for providers in region as no national measurement is available to match. PMPM amounts for the geographic regions will be compared with projected PMPM to determine cost savings. Through the use of the proposed CHIPRA measures, the adult Medicaid measures and the Meaningful Use measures, the State seeks to align with some of the information, including cost savings, which will be collected for the Report to Congress.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE ALABAMA

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreement with the Secretary of HHS. This agreement covers:

1. /_/ Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   /_/ YES /_/ NO

2. /X/ Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   /X/ YES /_/ NO

3. /_/ All individuals eligible under the State's approved title XIX plan.

4. /X/ Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

   Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE ALABAMA

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. Eligible categorical individuals as specified in A.2. above.

3.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ALABAMA

MEDICAID FOR MEDICARE COST SHARING FOR QUALIFIED MEDICARE BENEFICIARIES

Effective Date: 01/01/89

The Medicaid Agency pays Part A and Part B deductibles and coinsurance amounts for all individuals eligible under Medicare Catastrophic coverage. Medicaid's reimbursement methodologies are applied to crossover claims for these individuals, but Medicaid's benefit and coverage limitations are not applicable.

Cost-sharing for crossover claims will be applied as stated in Attachment 4.18-A.

Reimbursement Methodologies are described in Attachment 4.19-B, Item 19.

Orig.: Janice P
cc: Dale Walley

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administratic

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

SEP 17 1997

Dear State Medicaid Director:

This letter is the first of several providing policy guidance and clarification for the recent legislative changes under the Balanced Budget Act of 1997. It is critical for Federal and State Governments to work cooperatively to implement these recent legislative changes. I am looking forward to working with States and doing our part in realizing these Congressional health care goals.

The purpose of this letter is to inform you of the elimination of Obstetrical and Pediatric (Ob/Ped) payment rate requirements. Section 4713 of the Balanced Budget Act of 1997 repeals section 1926 of the Social Security Act (Assuring Adequate Payment Levels for Obstetrical and Pediatric Services) and applies to services furnished on or after October 1, 1997.

States will no longer be required to submit a State Plan Amendment (SPA) by April 1 of each year documenting access to Ob/Ped services, but the Health Care Financing Administration (HCFA) is still committed to improving access to care for pregnant women and children. Therefore, we remind you that under Section 1902(A)(30)(a) States' payments must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

We realize the difficulties that were encountered in obtaining data needed for the Ob/Ped SPAs and appreciate your past efforts. If your staff have questions about this letter, please have them contact your HCFA Regional Office.

Sincerely,

Sally K. Richardson
Director
Center for Medicaid and State Operations

cc:
All HCFA Regional Administrators

All HCFA Associate Regional Administrators
for Medicaid and State Operations

SEP 1997
Received
Administrative
Procedures Office

Lee Partridge
American Public Welfare Association

Joy Wilson
National Conference of State Legislature

Jennifer Baxendell
National Governors' Association

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

Standards for Medical Institutions

1. The following are types of institutions in which medical care or services may be provided under the Plan: hospitals, skilled nursing facilities, and intermediate care facilities.

2. Standards for these institutions are set forth in the publications "Alabama State Board of Health - Rules, Regulations, and Standards - Nursing Homes" (includes skilled and intermediate care facilities) and "Alabama State Board of Health - Rules, Regulations, and Standards - Hospitals." These publications are on file in the Administrative Procedures Office.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

Utilization Review in Intermediate Care Facilities; ICF/MR

Effective Date: 04/01/91

(1) Nursing Facilities utilization review is performed by Facility Based Review or by contract with a professional review organization.

Effective Date: 04/01/91

(2) ICF/MR utilization review is performed by Facility Based Review or by contract with a professional review organization. The Department of Mental Health will submit a utilization review plan to the Alabama Medicaid Agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Alabama

Cooperative Arrangements With Other Agencies

The Alabama Medicaid Agency has cooperative agreements with State Health and Vocational Rehabilitation Agencies, Title V Grantees, Title XIX Statewide Family Planning Project, and participating providers in support of this program that meet the requirements of 42 CFR 431.615. The services administered or supervised by those agencies will be utilized and coordinated with the medical care and services provided by the Alabama Medicaid Agency under the State Plan for Medical assistance. These agreements ensure that:

1. Persons eligible for medical care under Title XIX will be informed of rehabilitation and crippled children's services, Title V grantee services, and family planning services that are available to them through State agencies and will be encouraged to use them;

2. Personnel of vocational rehabilitation and crippled children agencies and the Family Planning Project will be kept informed of all services available through the medical assistance program, which will permit them to properly counsel their patients;

3. Vocational rehabilitation crippled children agencies, Title V grantee agencies and the Statewide Family Planning Project will be reimbursed for the cost of medical and rehabilitative care that is within the purview of the State Plan, in accordance with Federal and State Law and regulations;

4. Planning conferences on matters of mutual interests will be conducted at appropriate times;

5. Perinatal initiatives are aimed at improving infant morbidity & mortality. Outreach will be targeted in defined regions by Regional Directors;

6. Services to children with special needs is being enhanced and accomplished through revisions to the Medicaid/State Department of Education agreement regarding services provided through Children's Rehabilitation Services effective January 1, 1992.

Agreements pertaining to the services cited above and any others that may be added from time-to-time as related to these services will become a part of Attachment 4.16-A.

Effective Date:

7. Department of Public Health will develop, in collaboration with Medicaid, family planning materials and information sheets that may be utilized to enhance the services provided by Medicaid's Family Planning Program.

Agreements pertaining to the services cited above and any others that may be added from time-to-time as related to these services will become a part of Attachment 4.16-A.

AGREEMENT

Between

THE ALABAMA MEDICAID AGENCY

And

THE DIVISION OF LICENSURE AND CERTIFICATION
DEPARTMENT OF PUBLIC HEALTH

WHEREAS, Public Law 89-97 as amended and Public Law 92-603 require states desiring to participate in the Title XIX Program (Medicaid) to establish a plan for medical assistance, and

WHEREAS, the Office of the Governor has been designated as the single state agency responsible for the administration of the Alabama medical assistance program under Title XIX, and

WHEREAS, the Office of the Governor has delegated the Alabama Medicaid Agency as its agent to receive funds for and administer the Alabama Medicaid Agency Program under Title XIX of the Social Security Act, as amended, and the rules and regulations promulgated thereunder, and

WHEREAS, the Division of Licensure and Certification of the Alabama Department of Public Health, also referred as "DLC," has been designated as the agency to carry out the survey procedure for the Title XVIII program pursuant to Section 1864 of the Social Security Act, as amended, and

WHEREAS, in order to comply with Section 1902(a)(9) of the SSA as amended the Alabama Medicaid Agency elects to enter into a written contract with DLC to provide the Alabama Medicaid Agency with information concerning compliance with program requirements

through the survey process and on-site visits by qualified personnel for those facilities requesting to participate or participating in the Medicaid program;

NOW, THEREFORE, The Alabama Medicaid Agency and DLC agree to the following:

I. The Division of Licensure and Certification (DLC) will:

1. Provide Medicaid with copies of initial and periodic survey findings and recommendations for certification of hospitals, skilled nursing and intermediate care facilities, home health agencies, independent laboratories, rural health clinics, end stage renal dialysis facilities, ambulatory surgical centers, rehabilitation centers, and portable x-ray units applying to participate or participating in the Medicare and/or Medicaid programs, together with copies of written action taken thereon by the Department of Health and Human Services concerning Medicare recommendations. Periodic resurveys will be conducted at least once each year by qualified DLC personnel.
2. Provide Medicaid with post-certification revisit reports of all health care facilities on a timely basis.
3. Provide health care facilities applying to participate in the Medicaid program with the appropriate application forms and program instructions that relate to certification.

4. Conduct special surveys upon request by Medicaid if a question on noncompliance with the Federal Conditions of Participation arises. Such special surveys will be priority oriented and accomplished within the framework of DLC reasonable resources.
5. Provide Medicaid with the required documentation and related data in the event of voluntary and/or involuntary termination of all health care facilities.
6. Upon request, provide Medicaid with copies of approved hospital transfer agreements for skilled nursing and intermediate care facilities on initial surveys and changes of ownership.
7. Provide consultant services by personnel qualified in the fields of medicine, pharmacy, nursing, nutrition, patient activities, social services, fire safety, and other professional services when requested by Medicaid.
9. Prepare and submit a quarterly report of services performed by DLC for Medicaid.
10. Maintain a complete case file on each Medicaid participating facility, to include statements of deficiencies, plans of correction and certification, actions taken based upon findings submitted by DLC which will include any other information that may affect participation in the Medicaid program.
11. Provide Medicaid with copies of recommendations to the Licensure Advisory Board and/or State Committee of Public Health relating to licensure activities that involve

changes in regulations, licensure status and/or revocation of licenses of health care facilities and provide Medicaid with disposition of the hearings.

12. Make on-site visits to health care facilities to investigate complaints, and initiate follow-up action as necessary to meet the requirements for participation in the Medicaid program.
13. Carry out a continuing inservice education and staff development program for DLC and Medicaid staff as it relates to Title XIX functions.
14. As required by Section 1124 of the Social Security Act, provide ownership and control interest information of health care facilities to Medicaid as a prerequisite to facility participation or reimbursement under Title XIX.
15. Submit to Medicaid in sufficient time to allow for review and approval prior to the renewal date, a budget request for the services enumerated herein which will include the numbers and qualifications of persons required to perform these services. This budget shall be based upon a mutually agreeable annual schedule of activities.
16. Bill Medicaid on a monthly or other appropriate basis for estimated expenditures for the services rendered in the prior month and adjusted at the end of each quarter.
17. At the end of each quarter, furnish Medicaid with cost documents of certification activities based on the amount of time spent by each employee of the Division of

Licensure and Certification certified by Division of Finance, Alabama Department of Public Health.

II. The Alabama Medicaid Agency will:

1. As they are developed and become available, provide DLC with applicable program regulations relating to the survey process, needed interpretations of such regulations, and procedures setting forth the manner in which survey information is to be submitted to Medicaid.
2. Notify DLC of any requests received from potential providers to participate in the Medicaid program.
3. Submit requests for special surveys to DLC indicating the reason and priority for survey.
4. Based upon a review and evaluation of survey and site information and other relevant data, notify facilities of findings. Facilities found to be eligible for participation in the Medicaid program will be advised and offered an opportunity to enter into an agreement with Medicaid appropriate to the needs of Medicaid. Facilities found not eligible for participation in the Medicaid program will be so advised, along with reasons for denial.
5. Notify DLC of action taken relating to facility contract agreements.
6. Provide approved facilities with certificates of participation.
7. Submit complaints concerning health care facilities to DLC for investigation.

8. To the extent feasible and practicable, utilize information, data, and resources available through DLC in analyzing, assessing, and monitoring the Professional Review Organization.

9. Develop jointly with DLC appeal procedures available to skilled nursing and intermediate care facilities whose participation in the Medicaid program is being denied, terminated or not renewed.

10. Provide state matching money for each fiscal year for Title XIX survey and certification activities as set forth in the DLC budget and approved by Health Standards and Quality, Health Care Financing Administration, Department of Health and Human Services, Region IV.

III. This contract does not require DLC to survey or monitor Civil Rights requirements for the Alabama Medicaid Program.

IV. The terms of this agreement have been developed in accordance with program regulations and the Department of Health and Human Services' guidelines and are subject thereto. Terms of this agreement may be amended as agreed to in writing by both parties.

V. Under no circumstances shall a debt of the state of Alabama arise or be created under this agreement, as prohibited by Section 213 of the Constitution of Alabama of 1901, as amended.

TN NO. 87-10 DATE/RECEIPT 5/22/87
SUPERSEDES DATE/APPROVED 6/5/87
TN NO. 80-2 DATE/EFFECTIVE 4/1/87

VI. The term of this agreement is for one year from April 1, 1987, and this agreement shall continue from year to year thereafter unless cancelled by either party at any time upon written notice to the other party given at least ninety days prior to any termination date.

IN WITNESS WHEREOF, this agreement has been duly executed this the 13th day of May, 1987.

ALABAMA DEPARTMENT OF PUBLIC HEALTH

By: Carroll S. Hass
Director
Division of Licensure & Certification

DATE: 4/30/87

APPROVED AS TO FORM:
APPROVED AS TO FORM
DEPT. OF PUBLIC HEALTH
APR 30 1987
Attorney
LEGAL BRANCH
PER Jack Wilbe

APPROVED: [signature]
State Health Officer

DATE:

ALABAMA MEDICAID AGENCY

By: J. Michael Hanby
Commissioner
Alabama Medicaid Agency

DATE: May 8, 1987

APPROVED AS TO FORM:

W.D. Butler III
Attorney

APPROVED: Guy Hunt
Governor

DATE: 5-13-87

TN NO. 87-10 DATE/RECEIPT 5/22/87
SUPERSEDES DATE/APPROVED 6/5/87
TN NO. 80-22 DATE/EFFECTIVE 4/1/87

PROVIDER AGREEMENT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND
ALABAMA STATE DEPARTMENT OF EDUCATION
(Division of Rehabilitation and Crippled Children Service)

WHEREAS, the Alabama Medicaid Agency, hereinafter referred to as Medicaid, has been designated as the agency to administer the Medicaid Program in the State of Alabama under Title XIX of the Social Security Act, and

WHEREAS, the undersigned, the Alabama State Department of Education (Division of Rehabilitation and Crippled Children Service) hereinafter called SDE/CCS, is a duly certified or licensed provider of services and desires to participate in the Medicaid Program;

NOW, THEREFORE, the parties to this agreement hereby agree that SDE/CCS shall participate in the Alabama Medicaid Program for the purpose of providing services and/or goods pursuant to Title XIX of the Social Security Act, as amended, and under the terms and conditions set forth herein.

SECTION I. (GENERAL)

1. This agreement shall become effective on October 1, 1986, and shall continue until terminated, amended, or revised by either party in accordance with the terms and conditions of this agreement, with the exception that Medicaid may terminate this agreement when it determines that, during the last fiscal year, SDE/CCS has not provided services to Medicaid only recipients in excess of five claims and/or One Hundred Dollars ($100.00).

2. This agreement may be revised, altered, modified, or amended as required, provided that such is in writing and signed by both parties. This agreement may be terminated by either party upon thirty (30) days' written notice.

3. SDE/CCS shall comply with all the applicable provisions of the Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as amended, (hereinafter called the State Plan), and shall follow the procedures established for providing services under the Medicaid Program. SDE/CCS shall comply with all relevant Federal and State laws and regulations and shall follow the best professional practices consistent with reasonable economy.

AL 86-22 Approved 1/7/87
eff 10/1/86

4. This agreement is deemed to include the applicable provisions of the State Plan, Alabama Medicaid Administrative Code, and all State and Federal laws and regulations. If this agreement is deemed to be in violation of any of said provisions, then this agreement is deemed amended so as to comply therewith. Invalidity of any portion of this agreement shall not affect the validity, effectiveness, or enforceability of any other provision.

5. SDE/CCS shall maintain records at its normal place of business sufficient to verify and disclose the full extent of services, equipment, supplies, and/or goods furnished to Medicaid recipients. SDE/CCS agrees that:

a. All such records shall be maintained for a period of at least three years and one month following the last day of the fiscal year in which the service was rendered. However, if audit, litigation, or other action by or on behalf of the State of Alabama or Federal Government has begun but is not completed at the end of the above time period, or if audit findings, litigation, or other action has not been resolved at the end of the above time period, said records shall be retained until resolution.

b. SDE/CCS shall promptly make all such records available for inspection and audit by authorized representatives of the Comptroller General of the United States, the Secretary of Health and Human Services, the Office of Inspector General, the Alabama Medicaid Agency, and appropriate agencies of the State of Alabama. SDE/CCS shall either furnish copies of said records without cost to Medicaid or allow said records to be removed from the facility for reproduction. Such reports and facilities will be available for inspection upon request during regular business hours of SDE/CCS.

c. SDE/CCS shall maintain, preserve, and provide Medicaid access to all records affecting or reflecting costs of services, equipment, supplies, and/or goods furnished under this agreement.

TN# 86-22
approved 1/7/87
Eff. 10/1/86

d. SDE/CCS shall maintain, preserve, and provide Medicaid access to all records showing SDE/CCS's relationship to any brother-sister or parent or subsidiary corporations, partnerships or other form of business ventures.

6. SDE/CCS agrees:

a. Claims will be submitted in accordance with guidelines established by Medicaid and billing instructions provided by the Medicaid fiscal agent, said instructions being construed to be consistent with the rules and regulations of Medicaid, hereby incorporated by reference. SDE/CCS agrees to accept as payment in full the amount paid by the fiscal agent for a covered service(s), and will make no additional charge or charges for a covered service(s) to a recipient, or sponsor, or family thereof, except the designated and appropriate copayment amount where applicable.

b. To pay Medicaid any monies due under Medicaid regulations for payments made on behalf of the patient by third parties. SDE/CCS shall cooperate by obtaining and providing Medicaid with the name, address, and circumstances surrounding third parties who may be liable for payment of services whenever possible. SDE/CCS shall follow all procedures set forth in the Medicaid Agency Administrative Code, Third Party Section, with regard to reporting, billing, and collecting from third parties.

7. SDE/CCS shall comply with Titles VI and VII of the Civil Rights Act of 1964, the Federal Age Discrimination Act, and Section 504 of the Rehabilitation Act of 1973.

8. Neither Medicaid nor SDE/CCS is obligated under this agreement unless and until it is duly executed by its authorized representatives.

TN #86-22
approved 1/7/87
Eff. 10/1/86

9. Medicaid shall make no payment for services rendered in violation of this agreement. Payments made for services rendered in violation of this agreement may be recovered through appropriate administrative and/or legal action.

10. Medicaid's obligation to make payments hereunder is an obligation that is subject to the availability of State and Federal funds appropriated for Medicaid purposes.

11. SDE/CCS shall not charge Medicaid for services rendered on a no-cost basis to the general public.

12. SDE/CCS is prohibited from offering incentives (such as discounts, rebates, refunds, or other similar unearned gratuity or gratuities) other than an improvement(s) in the quality of service(s), for the purpose of soliciting the patronage of Medicaid recipients. Should SDE/CCS give a discount or rebate to the general public, a like amount shall be adjusted to the credit of Medicaid on the Medicaid claim form, or such other method as Medicaid may prescribe. Failure to make a voluntary adjustment by SDE/CCS shall authorize Medicaid to recover same by then existing administrative recoupment procedures or legal proceedings.

13. Payment by Medicaid for services furnished under this agreement shall be made in accordance with applicable State and Federal laws, regulations, and limitations. In no event shall the Medicaid payment exceed the amount charged to the general public for the same service.

14. Medicaid recognizes that SDE/CCS is required by various contracts with governmental agencies and others to maintain certain sliding fee scales and fee schedules. Nothing herein shall require SDE/CCS to vary or adjust its rates to Medicaid based upon any fees offered under such sliding scales or schedules, nor shall any fee paid under such contract be deemed to be a "discount" or "rebate."

15. In the event litigation is had concerning any part of this agreement, whether initiated by SDE/CCS or Medicaid, it is agreed that such litigation shall be had and conducted in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdiction of those respective courts. This provision is not intended to, nor shall it operate to, enlarge the jurisdiction of either of said courts, but is merely an agreement and stipulation as to venue.

SECTION II. (ELECTRONIC MEDIA CLAIMS)

1. Medicaid agrees that SDE/CCS may submit claims for covered services by use of electronic media, to wit: magnetic tape.

2. SDE/CCS hereby agrees to establish and maintain on file the signature of each recipient of services furnished by the SDE/CCS, or when applicable the signature of a responsible person on behalf of said recipient. Said signature shall be maintained for each claim submitted consistent with Alabama Medicaid Administrative Code Rule 560-X-1-.15, as amended, herein incorporated by reference.

3. SDE/CCS hereby agrees that the method of electronic media claims submission shall be governed by and submitted under the existing rules, regulations, and policy directives of Medicaid, herein incorporated by reference. SDE/CCS further agrees that said method of electronic media claims submission shall be governed by and submitted under the provisions of the Alabama Medicaid Agency Tape Billing Manual, as amended, herein incorporated by reference.

4. SDE/CCS hereby agrees to and shall be solely responsible for the accuracy and authenticity of said electronic media claims submitted. SDE/CCS shall retain and maintain detailed records, including original source documents which shall fully disclose the nature and extent of the service as reflected in the electronic media claims submitted for the time period reflected in Section I. 5. a.

5. SDE/CCS hereby certifies that the service described on the electronic media claim was personally rendered by the provider of service or under his personal direction. SDE/CCS further certifies that said service was medically necessary for the diagnosis and treatment of the condition as indicated by the diagnosis and shall maintain records, including source documents to verify such.

SECTION III. (PHYSICIAN SERVICES)

1. Each physician that renders services in the SDE/CCS clinic must be enrolled as a Medicaid provider with SDE/CCS as the payee.

2. SDE/CCS shall obtain and provide to Medicaid the provider enrollment information necessary for each physician to be enrolled in the Medicaid program with SDE/CCS as the payee.

3. This agreement entitles SDE/CCS to submit claims to Medicaid under the physician's provider number for the following procedure codes, and no others:

Z5145 - Regular Clinic
Z5146 - Speciality Clinic
Z5147 - Interdisciplinary Team Clinic (New Patient)
Z5148 - Interdisciplinary Team Clinic (Established Patient)

SECTION IV. (NONPHYSICIAN SERVICES)

1. The SDE/CCS clinic shall be enrolled under a separate provider number for filing of nonphysician services.

2. This agreement entitles SDE/CCS to submit claims for nonphysician services for the following procedure codes, and no others:

Z5149 - Hearing Clinic
V5010 - Hearing Aid Clinic
92591 - Hearing Aid Evaluation
92557 - Audiological Assessment
92506 - Hearing Evaluation
92507 - Hearing Therapy
70000-79999 - Radiology (Birmingham Office Only)
NZ2353 - Factor VIII
NZ2354 - Factor IX

3. Other nonphysician services may be added, by amendment to this contract, through an interagency agreement for improved EPSDT services.

SECTION V. (REIMBURSEMENT AMOUNTS)

1. Reimbursement shall be made in accordance with the following Pricing Schedule.

NZ2353 - .10¢ per unit
NZ2354 - .10¢ per unit

V5010 - $31.00
Z5145 - $ 5.00
Z5146 - $ 7.00
Z5147 - $35.00
Z5148 - $ 7.00
Z5149 - $43.00

70000--79999 - According to Level III Pricing

92506 - $35.00
92507 - $15.00
92557 - $35.00
92591 - $31.50

SECTION VI. (RECIPROCAL REFERRALS.

1. Efforts will be made to inform all clients who are eligible for Medicaid and who are clients of SDE/CCS of the availability of services provided by the Alabama Medicaid Program.

2. Medicaid will refer Medicaid-eligible persons to SDE/CCS for services provided by that agency that are not covered by the Medicaid State Plan.

SECTION VII. (FILES ACCESS)

1. The Alabama Medicaid Agency authorizes SDE/CCS to access and utilize data contained in the following files which are part of the Alabama Medicaid Management Information System (AMMIS):

1. SDX Master
2. Eligibility File
3. Insurance Company File

and any other files as deemed pertinent and necessary by employees of SDE/CCS in the performance of their official duties. This information will be safeguarded in accordance with 42 C.F.R. §431.306.

2. SDE/CCS authorizes Medicaid to access and utilize data contained in SDE/CCS's insurance file and any other files as deemed pertinent and necessary by employees of Medicaid in the performance of their official duties. This information will be safeguarded in accordance with 42 C.F.R. §431.306.

SECTION VIII. (LIAISON)

1. SDE/CCS and Medicaid agree to meet at mutually agreed times to discuss the concerns of either agency.

2. SDE/CCS and Medicaid agree to meet at mutually agreed times to discuss and plan for improved services to Medicaid recipients mutually eligible for EPSDT and Crippled Children Service Programs.

ALABAMA STATE DEPARTMENT OF EDUCATION

Lamona H. Lucas, Director
Division of Rehabilitation and Crippled Children Service

William J. Rutherford, Director
Division of Administrative and Financial Services

Wayne Teague
State Superintendent of Education

Date _____

Approved for legal form
Office of General Counsel
Department of Education
by _____

ALABAMA MEDICAID AGENCY

Faye S. Baggiano, Commissioner
Alabama Medicaid Agency

Date _____

APPROVED:

George C. Wallace
Governor of Alabama

A. M. Mitchell
State Finance Director

Approved as to form:

PROVIDER AGREEMENT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND
ALABAMA STATE DEPARTMENT OF EDUCATION
(Division of Rehabilitation and Crippled Children Service)

AMENDMENT NUMBER 1

WHEREAS, the Alabama Medicaid Agency and the Alabama State Department of Education (Division of Rehabilitation and Crippled Children Service) entered into a provider agreement, effective October 1, 1986, for the provision and payment of certain services to be provided to recipients of the Alabama Medicaid Program; and

WHEREAS, said parties desire to enlarge the services covered by said provider agreement;

NOW, THEREFORE, the parties agree that said contract is amended to include the following provisions:

A. SECTION IV (NONPHYSICIAN SERVICES), paragraph 2 is amended to add as a covered procedure code:

"92581 - Evoked Response Audiometry"

B. SECTION V (REIMBURSEMENT AMOUNTS), paragraph 1 is amended to add at the end:

"92581 -- $80.00"

This Amendment shall be effective as of December 1, 1987 .
(Date)

Except as expressly provided herein, said provider contract shall remain in full force and effect as originally executed.

Executed this 14th day of October, 1987.

ALABAMA STATE DEPARTMENT OF EDUCATION

By _____
Lamona H. Lucas, Director
Division of Rehabilitation and
Crippled Children Service

ALABAMA MEDICAID AGENCY

By _____
J. Michael Horsley, Commissioner
Alabama Medicaid Agency

TN No. 87-25 DATE/RECEIPT 11/13/87
SUPERSEDES DATE/APPROVED 12/11/87
TN No. 81-9 DATE/EFFECTIVE 12/1/87

By William J. Rutherford
William J. Rutherford, Director
Division of Administrative
and Financial Services

By Wayne Teague
Wayne Teague
State Superintendent of Education

APPROVED AS TO FORM:

Jim R. Ippolito, Jr.
Counsel

APPROVED AS TO FORM:

William O. Butler, III
Counsel

APPROVED:

Does not require
Finance Director's
signature

G. Robin Swift, Jr.
State Finance Director

Guy Hunt
Guy Hunt
Governor of Alabama

TN NO. 87-25 DATE/RECEIPT 11/13/87
SUPERSEDES DATE/APPROVED 12/11/87
TN NO. 81-9 DATE/EFFECTIVE 12/1/87

AL-88-5
Attachment 4.16-A
Amendment Number 2

CONTRACT NO. 70051

PROVIDER AGREEMENT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND
ALABAMA STATE DEPARTMENT OF EDUCATION
(Division of Rehabilitation and Crippled Children Service)

Amendment Number 2

WHEREAS, the Alabama Medicaid Agency and the Alabama State Department of Education (Division of Rehabilitation and Crippled Children Service) executed an agreement effective October 1, 1986, and desire to amend the same so as to make it acceptable to federal authorities for providing of services under the Alabama Medicaid Program;

NOW, THEREFORE, the parties hereby agree to the following addition to said written agreement (contract):

"Section IX (Reimbursement Limits)

1. Reimbursement for any services provided hereunder shall not exceed the provider's actual cost.

2. Reimbursement for any services provided hereunder will not exceed the amounts paid for similar services to other providers under the Alabama Medicaid Program."

This amendment shall have the same effective date as the original agreement.

Executed November 25, 1987

ALABAMA STATE DEPARTMENT OF EDUCATION

Lamona H. Lucas, Director
Division of Rehabilitation and Crippled Children Service

ALABAMA MEDICAID AGENCY

S. Michael Horsley,
Commissioner
Alabama Medicaid Agency

Date: 1-25-88

TN No. 88-5 SUPERSEDES TN No. ____

DATE/RECEIPT 2/25/88
DATE/APPROVED 3/2/88
DATE/EFFECTIVE 1/1/88

Contract No. 70051

APPROVED:

William J. Rutherford

William J. Rutherford
Assistant State Superintendent of Education
for Administrative and Financial Services

Guy Hunt

Guy Hunt
Governor of Alabama

Wayne Teague

Wayne Teague
State Superintendent of Education

Does not require
Finance Director's

G. Robin Swift, Jr.
Finance Director

Office of [illegible]nsel
Department of Education
by _____

Approved as to form:

William O. Butler III

TN No. 88-5 DATE/RECEIPT 2/25/88
SUPERSEDES DATE/APPROVED 3/2/88
TN No. _____ DATE/EFFECTIVE 1/1/88

CONTRACT NO. 70051

PROVIDER AGREEMENT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND
ALABAMA STATE DEPARTMENT OF EDUCATION
(Division of Rehabilitation and Crippled Children Service)

AMENDMENT NUMBER 3

WHEREAS, the Alabama Medicaid Agency and the Alabama State Department of Education (Division of Rehabilitation and Crippled Children Service) entered into a provider agreement, effective October 1, 1986, for the provision and payment of certain services to be provided to recipients of the Alabama Medicaid Program; and

WHEREAS, said parties wish to amend the agreement to add Early and Periodic Screening, Diagnosis, and Treatment as a covered service;

NOW, THEREFORE, said parties agree that said agreement is amended effective July 1, 1988, by adding the following:

SECTION X. (EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES)

1. Persons eligible for the Early and Periodic Screening, Diagnosis, and Treatment (hereinafter called "EPSDT") Program benefits are those persons under twenty-one (21) years of age, who are certified by the Alabama Medicaid Agency as eligible for Medicaid benefits.

2. Persons requesting screening services must receive the screening examination within one hundred and twenty (120) days from the date the services are requested.

3. Persons referred for further diagnosis and treatment should receive such services within one hundred and twenty (120) days from the date referral services are requested.

4. The SDE/CCS will make any necessary follow-up to assure that eligible children receive EPSDT services provided by this Program.

5. Medicaid will furnish instructions for EPSDT.

6. SDE/CCS agrees to carry out the complete EPSDT examination of eligible persons as prescribed by Medicaid in its EPSDT screening or examination package, the EPSDT instructions, the State regulations and all applicable Federal regulations.

TN No. 88-19 SUPERSEDES TN No. NEW DATE/RECEIPT 10/17/88 DATE/APPROVED 4/19/89 DATE/EFFECTIVE 7/1/88

7. SDE/CCS agrees to abide by the Medicaid procedures established for statewide administration of the EPSDT Program.

8. Upon request of SDE/CCS, Medicaid will provide professional consultation in physical assessment, and consultation and technical assistance in solving other problems related to the EPSDT Program.

9. Medicaid will furnish statistical data to SDE/CCS in a form to be determined by Medicaid (for program management purposes).

10. SDE/CCS will submit claims for payment to Medicaid's fiscal agent in accordance with instructions issued by Medicaid and its fiscal agent.

11. The Alabama Medicaid Agency, through its fiscal agent, will reimburse SDE/CCS at the rates established and in use at the time of examination.

12. SDE/CCS shall inform Medicaid-eligible persons that they may receive Medicaid covered services from a provider of their choice.

13. Under no circumstances shall the commitment under this agreement constitute a debt of the State of Alabama, as prohibited by Section 213, Constitution of Alabama of 1901, as amended by Amendment XXVI.

14. The SDE/CCS clinic shall be enrolled under a separate provider number for each clinic site for filing of EPSDT services.

15. This agreement entitles SDE/CCS to submit screening summary claim forms for the following procedure codes, and no others:

Z5115 - Initial EPSDT Screening, Normal Findings
Z5116 - Initial EPSDT Screening, Abnormal Findings
Z5154 - Periodic EPSDT Screening, Normal Findings
Z5155 - Periodic EPSDT Screening, Abnormal Findings
Z5156 - Nonperiodic EPSDT Screening, Normal Findings
Z5157 - Nonperiodic EPSDT Screening, Abnormal Findings

16. Other EPSDT services may be added, by amendment to this agreement, through an interagency agreement for improved EPSDT services.

Except as expressly provided herein, said provider agreement shall remain in full force and effect as originally executed.

Executed this 1st day of July, 1988.

TN No. 88-19 SUPERSEDES TN No. NEW
DATE/RECEIPT 10/12/88
DATE/APPROVED 4/18/89
DATE/EFFECTIVE 8/1/88

AMENDMENT NUMBER 3
Page 3

ALABAMA STATE DEPARTMENT OF EDUCATION

By _____
Lamona H. Lucas, Director
Division of Rehabilitation and Crippled Children Service

By _____
William J. Rutherford, Director
Division of Administrative and Financial Services

By _____
Wayne Teague
State Superintendent of Education

APPROVED AS TO FORM:

_____
Counsel

ALABAMA MEDICAID AGENCY

By _____
J. Michael Horsley, Commissioner
Alabama Medicaid Agency

Does not require
Finance Director's
signature

_____
G. Robin Swift, Jr.
State Finance Director

_____
Guy Hunt
Governor of Alabama

APPROVED AS TO FORM:

William O. Butler III
Counsel

Approved for legal form
Office of General Counsel
Department of Education
by _____

TN No. 88-19 DATE/RECEIPT 10/17/88
SUPERSEDES DATE/APPROVED 1/19/89
TN No. NEW DATE/EFFECTIVE 10/1/88

Contract 70051
Amendment no. 4

PROVIDER AGREEMENT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND
ALABAMA STATE DEPARTMENT OF EDUCATION
(Division of Rehabilitation and Crippled Children Service)

AMENDMENT NUMBER 4

WHEREAS, the Alabama Medicaid Agency and the Alabama State Department of Education (Division of Rehabilitation and Crippled Children Service) entered into a provider agreement, effective October 1, 1986, for the provision and payment of certain services to be provided to recipients of the Alabama Medicaid Program; and

NOW, THEREFORE, the parties hereby agree to the following amendment to said written agreement (contract):

B. SECTION V (REIMBURSEMENT AMOUNTS), paragraph 1 is amended as follows:

"NZ2353 - 50 cents per unit"
"NZ2354 - 10 cents per unit"

This Amendment shall be effective as of July 1, 1988.

Except as expressly provided herein, said provider agreement shall remain in full force and effect as originally executed.

Executed this 1st day of July, 1988.

ALABAMA STATE DEPARTMENT OF EDUCATION

By _____
Lamona H. Lucas, Director
Division of Rehabilitation and Crippled Children Service

By _____
William J. Rutherford, Director
Division of Administrative and Financial Services

By _____
Wayne Teague
State Superintendent of Education

APPROVED AS TO FORM:
Approved for legal form
Office of [illegible] Counsel
Department of Education

ALABAMA MEDICAID AGENCY

By _____
J. Michael Horsley, Commissioner
Alabama Medicaid Agency

Does not require Finance Director's signature

G. Robin Swift, Jr.
State Finance Director

Guy Hunt
Governor of Alabama

APPROVED AS TO FORM:

William O. Butler III

EM No. 88-21
SUPERSEDES
EM No. ____
DATE RECEIVED 11/8/88
DATE/TIME EFFECTIVE 11/8/88

Contract No: 70051
Amendment No. 5

PROVIDER AGREEMENT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND
ALABAMA STATE DEPARTMENT OF EDUCATION
(Division of Rehabilitation and Crippled Children Service)

AMENDMENT NUMBER 5

WHEREAS, the Alabama Medicaid Agency and the Alabama State Department of Education (Division of Rehabilitation and Crippled Children Service) entered into a provider agreement, effective October 1, 1986, for the provision and payment of certain services to be provided to recipients of the Alabama Medicaid Program; and

WHEREAS, the above parties, entered into Amendment Number 3 of said agreement on July 1, 1988, to add Early and Periodic Screening, Diagnosis, and Treatment Services;

NOW, THEREFORE, the parties hereby amend Section X, paragraph 3, to said written agreement (contract) as added by Amendment Number 3 as follows:

SECTION X (EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES)

"3. Persons referred for further diagnosis and treatment should receive such services within sixty (60) days from the date referral services are requested."

Except as expressly provided herein, said provider agreement shall remain in full force and effect as originally executed.

Executed this 25th day of May, 1989.

ALABAMA STATE DEPARTMENT OF EDUCATION

By Lamona H. Lucas
Lamona H. Lucas, Director
Division of Rehabilitation and Crippled Children Service

By William J. Rutherford
William J. Rutherford, Assistant State Superintendent for Administrative and Financial Services

By Wayne Teague
Wayne Teague
State Superintendent of Education

APPROVED AS TO FORM:

By _____
Counsel

ALABAMA MEDICAID AGENCY

By Carol A. Herrmann
Carol A. Herrmann, Commissioner
Alabama Medicaid Agency

By Guy Hunt
Guy Hunt
Governor of Alabama

Does not require
Finance Director's
signature

Approved for legal form
Office of General Counsel
Department of Education
by _____

APPROVED AS TO FORM:

By William O Butler III
Counsel

TN NO. 89-15 DATE/RECEIPT 7/5/89
SUPERSEDES DATE/APPROVED 7/21/89
TN NO. NEW DATE/EFFECTIVE 6/30/89

Contract No. 70051
Amendment No. 6

PROVIDER AGREEMENT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND
ALABAMA STATE DEPARTMENT OF EDUCATION
(Division of Rehabilitation and Crippled Children Service)

AMENDMENT NUMBER 6

WHEREAS, the Alabama Medicaid Agency and the Alabama State Department of Education (Division of Rehabilitation and Crippled Children Service) entered into a provider agreement, effective October 1, 1986, for the provision and payment of certain services to be provided to recipients of the Alabama Medicaid Program; and

WHEREAS, the above parties, entered into Amendment Number 4 of said agreement on July 1, 1988, to amend the reimbursement amounts of procedure codes NZ2343 and NZ2354;

NOW, THEREFORE, the parties hereby amend Section V to said written agreement as amended by Amendment Number 4 as follows:

SECTION V (REIMBURSEMENT AMOUNTS)

"NZ2353 - 75 cents per unit"

This Amendment shall be effective as of April 1, 1989.

Except as expressly provided herein, said provider agreement shall remain in full force and effect as originally executed.

Executed this 25th day of May, 1989.

ALABAMA STATE DEPARTMENT OF EDUCATION

By Lamona H. Lucas
Lamona H. Lucas, Director
Division of Rehabilitation and Crippled Children Service

By William J. Rutherford
William J. Rutherford, Assistant State Superintendent for Administrative and Financial Services

By Wayne Teague
Wayne Teague
State Superintendent of Education

APPROVED AS TO FORM:

By _____
Counsel

ALABAMA MEDICAID AGENCY

By Carol A. Herrmann
Carol A. Herrmann, Commissioner
Alabama Medicaid Agency

By Guy Hunt
Guy Hunt
Governor of Alabama

Does not require Finance Director's signature

Approved for legal form
Office of General Counsel
Department of Education
by [illegible]

APPROVED AS TO FORM:

By William O Bottle III
Counsel

TN No. 89-15 DATE/RECEIPT 7/5/89
SUPERSEDES DATE/APPROVED 7/21/89
TN NO. NEW DATE/EFFECTIVE 6/30/89

PROVIDER AGREEMENT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND
ALABAMA STATE DEPARTMENT OF EDUCATION
(Division of Rehabilitation and Crippled Children Service)

AMENDMENT NUMBER 7

WHEREAS, the Alabama Medicaid Agency and the Alabama State Department of Education, Division of Rehabilitation and Crippled Children Service, hereinafter called (SDE/CCS) entered into a provider agreement, effective October 1, 1986, for the provision and payment of certain services to be provided to recipients of the Alabama Medicaid Program; and

NOW, THEREFORE, the parties hereby amend said written agreement (contract) by adding Amendment Number 7 as follows:

SECTION XI MEDICALLY NECESSARY ORTHODONTIC SERVICES

1. Persons eligible for Medically Necessary Orthodontic Services are those persons eligible for the Early and Periodic Screening, Diagnosis, and Treatment (hereinafter called "EPSDT") Program and who are certified by the Alabama Medicaid Agency as eligible for Medicaid benefits.

2. SDE/CCS must obtain prior authorization from the Alabama Medicaid Agency for all medically necessary orthodontic treatment.

3. SDE/CCS orthodontic clinic health care professional staffing shall include, but not be limited, to the following:

a. Orthodontist
b. Dentist (preferably Pedodontist)
c. Plastic Surgeon
d. Otolaryngologist
e. Pediatrician

4. SDE/CCS agrees that orthodontia will be added to the currently covered multidisciplinary team approach for the diagnosis, treatment planning, implementation and follow-up treatment for diagnoses including, but not limited to, the following:

a. Cleft lip/palate
b. Velopharyngeal incompetence
c. Short palate
d. Submucous cleft
e. Alveolar notch
f. Oral-facial anomalies
    1. Apert's syndrome
    2. Crouzon's syndrome

5. This agreement entitles SDE/CCS to submit claims for the following procedure codes and no others:

D0110 - Initial Oral Examination
D0330 - Panoramic Film
D0340 - Cephalometric Film
D0470 - Diagnostic Casts
D0471 - Diagnostic Photographs
D8650 - Treatment of Atypical or Extended Skeletal Case
D8750 - Post-treatment Stabilization
D9240 - Intravenous Sedation
D9310 - Consultation

6. Medicaid, through its fiscal agent, will reimburse SDE/CCS at the rates established and in use at the time of service.

7. SDE/CCS certifies that the services performed will be by staff members licensed in the state in which the services are rendered and also the providers of orthodontic services will be graduates of a certified and accredited school of orthodontia.

This amendment shall be effective as of July 1, 1989.

Except as expressly provided herein, said provider agreement shall remain in full force and effect as originally executed.

Executed this 7th day of Sept, 1989.

ALABAMA STATE DEPARTMENT OF EDUCATION

By Lamona H. Lucas
Lamona H. Lucas, Director
Division of Rehabilitation and Crippled Children Service

By William J. Rutherford
William J. Rutherford, Assistant State Superintendent for Administrative and Financial Services

By Wayne Teague
Wayne Teague
State Superintendent of Education

Approved for legal form
Office of General Counsel
Department of Education
by RNM 7/12/89

ALABAMA MEDICAID AGENCY

By Carol A. Herrmann
Carol A. Herrmann, Commissioner
Alabama Medicaid Agency

By Guy Hunt
Guy Hunt
Governor of Alabama

Does not require Finance Director's signature

APPROVED AS TO FORM:

By Peggy Schmitz
Counsel

TN No. 89-20 SUPERSEDES TN No. NEW
DATE/RECEIPT 9/29/89
DATE/APPROVED 10/16/89
DATE/EFFECTIVE 7/1/89

AGREEMENT
BETWEEN
MEDICAL SERVICES ADMINISTRATION
and the
STATEWIDE FAMILY PLANNING PROJECT
Alabama Department of Public Health

Attachment 4.16-A

This Agreement supersedes the Agreement between Medical Services Administration and the Statewide Family Planning Project with effective date of October 1, 1975, and all addenda thereto prior to effective date of the here-under Agreement, October 1, 1977.

In accordance with the terms of this agreement, the Statewide Family Planning Project, Alabama Department of Public Health, will provide family planning services, directly or under arrangements with others, to individuals who desire such services and who are eligible under the Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act.

I. GENERAL

A. Contraception: Contraceptive services include any medically approved means furnished or prescribed by or under the supervision of a physician for eligible individuals for purposes of enabling such persons freely to determine the number and spacing of their children, and to prevent the occurrence of unwanted pregnancies.

1. Contraceptive services include:

a. Gynecological and obstetrical history with previous contraceptive history, age at menarche, date of last normal menstrual period, gravidity, parity, pregnancy outcome, and other gynecological and obstetrical information which might influence the choice of a method of contraception.

b. Medical and surgical history with a systemic review of the following systems: cardiovascular, endocrine, hepatic, renal, hematologic, neoplastic, neurologic, psychiatric and previous contraceptive history.

c. Laboratory services including hemoglobin or hemocrit, urinalysis, VDRL, Sickle Cell screening, Papanicolaou smear, pregnancy testing and Gonorrhea Culture.

d. The female physical examination includes thyroid palpation, breast examinations and teaching self-breast examination; abdominal palpation, complete pelvic examination including the external genitalia, visualization of cervix, and bimanual, and recto-vaginal examination.

e. Male physical examination should emphasize the genital and rectal areas.

f. Patient education shall include the importance of family planning for the client and her family; basic male and female reproductive anatomy and physiology; information and teaching on all methods of contraception including hormonal oral contraceptive pills, intrauterine devices, diaphragms, foam, jellies, creams, condoms, coitus interruptus, rhythm,

natural family planning, and male or female sterilization. In addition, information on contraceptive methods' safety, potential side effects, effectiveness, alternatives and correct usage of the method chosen will be provided. Educational literature will be distributed to each patient with detailed information on the contraceptive method prescribed.

g. Patients' informed consent for voluntary acceptance of the family planning program services must be completed and signed (not applicable for sterilization as another form must be completed.)

2. For patients choosing oral contraception who cannot tolerate oral contraceptives furnished by Family Planning clinics, oral contraceptive drugs which are included in the Alabama Drug Code Index may be prescribed for eligible individuals. Physicians may prescribe one month's supply by indicating the unit as 20, 21, or 28; three months' supply by 60, 63, or 84. Six months' supply can be prescribed by prescribing three months' supply and indicating one refill on the prescription.

3. Drugs for other treatment which may be required are also covered in the Alabama Drug Code Index for Title XIX Medicaid and physicians may prescribe them for Medicaid-eligible individuals.

B. Sterilization: Appropriate referrals for sterilization shall be made of persons twenty-one (21) or more years of age who are legally competent to give informed consent, and who voluntarily request such services. Non-emergency and non-therapeutic sterilization, including tubal ligation and vasectomy, of eligible individuals is covered under the Alabama Medicaid program subject to restrictions and special requirements of Part 205, Chapter II, Title 45 of the Code of Federal regulations as amended by paragraph 205.35, effective April 18, 1974, and to established policy of the Medical Services Administration. (See Special Alabama Medicaid Information Letters, FP-76-3 and FP-77-1 and Form S-FP-1 (Rev. 7/76) attached.)

C. Infertility Services: Appropriate referrals shall be made of individuals who seek advice concerning infertility. Examinations, counselling, and corrective procedures for infertility problems for eligible individuals are covered under the Alabama Medicaid program.

D. Counselling and Referral: Appropriate counselling will be provided and/or indicated referrals made of individuals seeking special services, as sterilization services including vasectomies (See I.B), infertility services, other medical problems and abortions where the life of the mother would be endangered if the fetus were carried to term. The use of Federal XIX funds for payment for abortions applies in the following circumstances:

1. Payment may be made for abortions where the attending physician, on the basis of his or her professional judgment, has certified that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term.

2. Payment may be made for medical procedures necessary for the termination of an ectopic pregnancy.

3. a. Payment may be made for the treatment of rape or incest victims by the use of drugs or devices to prevent implantation of the fertilized ovum.

   b. Treatment of rape or incest victims is limited for these purposes to prompt treatment before the fact of pregnancy is established.

   c. As in all cases, payment may be made for abortions for rape or incest victims where the physician has certified that the life of the mother would be endangered if the fetus were carried to term.

4. Non-therapeutic abortions are not covered services of Alabama Medicaid.

E. Eligible Individuals: Eligible individuals are those persons of either sex considered to be fertile, including minors who may be sexually active, without regard to marital status who are certified by the Alabama State Department of Pensions and Security to Medical Services Administration as eligible for Medicaid benefits. It is understood that eligibility for Medicaid benefits may be terminated by the Department of Pensions and Security effective at the beginning of any calendar month.

F. Voluntary Participation: The acceptance by any individual of family planning information or services shall be voluntary, and without any form of duress or coercion applied to gain such acceptance.

STANDARDS

Family Planning services covered by the terms of this Agreement shall be provided in conformity with the Program Guidelines for Project Grants for Family Planning Services under Section 1001, Public Health Service Act.

III. SPECIFIC RESPONSIBILITIES OF THE STATEWIDE FAMILY PLANNING PROJECT

A. The Family Planning Project will offer medically approved methods for family planning, assist each individual in choosing a contraceptive method, provide follow-up and counselling as necessary to assure effective use of chosen method, and offer alternative methods if indicated.

B. The Family Planning Project will inform Medicaid-eligible persons of the availability of family planning services through mass media, personal contacts, pamphlets, and inter-agency cooperation.

C. The Family Planning Project will establish and maintain clinic services during evening hours and on Saturdays as the need arises, and as economically feasible.

D. The Family Planning Project may assist in providing transportation, particularly in rural areas, for individuals who would otherwise be unable to attend family planning clinics or obtain access to referral services. Project employees may assist in providing transportation for patients in need of this service with reimbursement for mileage paid by the Project.

E. Family Planning services will be under the medical responsibility and supervision of physicians.

F. The Family Planning Project shall keep such records as are necessary fully to disclose the extent of services provided to eligible individuals and the costs thereof and will furnish the Medical Services Administration or its duly authorized agents with such information regarding payment of claims as may be required from time to time. All records shall be kept for a period of three years.

G. The records of the Family Planning Project pertaining to this Agreement shall be subject to inspection and audit by representatives of the Comptroller General of the United States, the Secretary of the Department of Health, Education and Welfare, the Medical Services Administration or its authorized agents, and auditors of the State of Alabama.

H. The Family Planning Project shall furnish the Medical Services Administration such information as may be required for program evaluation, or to meet reporting requirements of the Department of Health, Education and Welfare, insofar as such information is available to the Family Planning Project.

I. The Family Planning Project agrees to operate under the provisions of Title VI of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973. Under the provisions of these Acts, any provider of services receiving Federal funds must comply with the intent of these Acts and this means there shall be no discrimination because of race, color, creed, national origin, physical or mental handicap. These Acts also provide for strict compliance and complaint procedures.

J. The Alabama Statewide Family Planning Project will correct, within ninety (90) days, any significant medical or clinic deficiencies found in the provision of family planning services and reported to Statewide Family Planning Project by the Medicaid representatives. A report will be submitted to Medical Services Administration outlining the corrective measures to be undertaken within 30 days.

IV. REIMBURSEMENT

A. Medical Services Administration through its fiscal agent will reimburse the Statewide Family Planning Project at a negotiated rate per patient clinic visit for family planning services. Such rate will be based on cost related reasonable charges for services provided and will be renegotiated by the contracting parties as cost experience indicates the need for change in the agreed rate.

B. Reimbursement will be made by Medical Services Administration only if both of the following conditions are met by the Family Planning Project:

1. The Family Planning Project asks every individual served by the program if he has third party benefits for family planning services; and

2. The Family Planning Project bills all third party payers for reimbursable family planning services.

C. Medical Services Administration reserves the right to refuse payment to clinics with reported specific program deficiencies not corrected within ninety (90) days after notice of deficiencies is given to the Statewide Family Planning Project.

V. CLAIMS

Claims will be submitted to Medical Services Administration by computer tape and printout and will include such information as agreed upon by the contracting parties.

VI. MISCELLANEOUS TERMS

A. This Agreement shall be for an initial term of one (1) year from the effective date hereof and shall continue from year to year thereafter unless cancelled by either party at any time upon written notice to the other party given at least (30) days prior to any termination date.

B. This Agreement may be amended by written agreement duly executed by the parties. No alterations or variations of the terms of this Agreement shall be valid unless made in writing and duly signed by the parties hereto; no oral understandings or agreements not incorporated here in and no alterations or variations of the terms hereof shall be binding on the parties unless so made in writing. Each such amendment shall specify the date its provisions shall be effective as agreed to by the parties.

C. All provisions of this Agreement are subject to availability of Medicaid funds.

IN WITNESS WHEREOF, this Agreement has been executed by the Medical Services Administration and the Statewide Family Planning Project by their authorized officers with an effective date of October 1, 1977.

STATEWIDE FAMILY PLANNING PROJECT
Department of Public Health

BY [signature]

TITLE MCH Director

DATE 11/2/77

MEDICAL SERVICES ADMINISTRATION

BY [signature]

TITLE Contract Officer

DATE August 29, 1977

DEPARTMENT OF PUBLIC HEALTH

BY [signature]

IRA L. MYERS, MD

TITLE STATE HEALTH OFFICER

DATE 11-29-77

4-1-81

AGREEMENT
BETWEEN
MEDICAL SERVICES ADMINISTRATION
and the
STATEWIDE FAMILY PLANNING PROJECT
Alabama Department of Public Health

Addendum:

It is mutually agreed by Statewide Family Planning Project and Medical Services Administration that the terms and conditions contained in the approved Agreement for family planning services of October 1, 1977, are hereby extended effective October 1, 1980 through September 30, 1981 and shall continue from year to year thereafter, unless cancelled by either party at any time upon written notice to the other party at least thirty (30) days prior to any termination date.

STATEWIDE FAMILY PLANNING PROJECT
Department of Public Health

BY _____
Robert L. Goldenberg, M.D.

TITLE Director of Bureau Maternal and Child Health/Family Planning

DATE 7-21-80

MEDICAL SERVICES ADMINISTRATION

BY _____
(Mrs.) Harriette M. Worthington

TITLE ~~Director of Program Administra~~ Administrator, Provider Enrollment and Prior Authorization

DATE July 25, 1980

DEPARTMENT OF PUBLIC HEALTH

BY _____
Ira L. Myers, M.D.

TITLE State Health Officer

DATE July 15, 1980

State of Alabama
Department of Public Health
State Office Building
Montgomery, Alabama 36130

October 17, 1977

IRA L. MYERS, M. D.
STATE HEALTH OFFICER

MEMORANDUM

SUBJECT: General Provisions of Section 504 of the Rehabilitation Act of 1973

As part of the Rehabilitation Act of 1973 (Public Law 93-112), Congress enacted Section 504. The Department of Health, Education and Welfare (DHEW) has published regulations (Federal Register, Vol. 42, No. 86, dated Wednesday, May 4, 1977) implementing Section 504, effective June 3, 1977. The regulations provide that:

> "no otherwise qualified handicapped individual in the United States, as defined in section 7(6), shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

The principles developed under the Civil Rights Act of 1964 and Equal Employment Amendments of 1972 were used as a basis for DHEW's 504 regulations. (Other federal agencies will publish regulations patterned after DHEW's 504 regulations, i.e., Department of Labor, Department of Transportation, Department of Agriculture, etc.).

The procedural provisions applicable to Title VI of the Civil Rights Act of 1964 are applicable to Section 504 of the Rehabilitation Act of 1973. The Department of Health, Education and Welfare will rely on state agencies (i.e., Medicaid, etc.) as it has under Title VI for monitoring compliance by individual providers.

Compliance with the regulations require the following administrative actions:

1. Sign and submit an Assurance of Compliance.

2. Designate at least one person to coordinate its efforts to comply with DHEW regulations.

3. Establish grievance procedures that provide appropriate Due Process (Fair Hearing).

4. Adopt and notify public of its policy of nondiscrimination against the handicapped in such a manner so as to ensure that handicapped persons, i.e., blind, deaf, etc., receive such notice.

5. Establish administrative procedures to be used in implementing regulation requirements.

6. Any program of services must be accessible and provided in such a manner that will:

   1. Provide the handicapped an opportunity to receive services provided in a manner that is equal to that of non-handicapped.

   2. Provide employment opportunities.

ccessibility is basic to Section 504 and requires the removal of any (structural nd nonstructural) barriers to programs. Compliance with this part requires two elf-evaluations:

1. Nonstructural Barriers (policies and practices): Subpart A, Section 84.6(c) requires a self-evaluation of current policies and practices for the purpose of modifying existing policies and/or adopting new policies to comply with this part. This will include, but not limited to, the following areas:

   a. Recruiting and employment policies.

   b. Employee benefit programs.

   c. Admitting/acceptance policies.

   d. Internal procedures for communication with persons having impaired hearing or vision.

2. Structural Barriers (architectural/physical): Subpart C, Section 84.22(a) requires program accessibility in existing facilities. Paragraph B provides certain (alternatives to structural changes) methods for achieving program accessibility. Paragraph C requires that in the event structural changes are necessary to meet requirements of Paragraph A, a transition plan be developed and include the following:

   a. Identify physical obstacles.

   b. Describe methods to be used in removing these obstacles.

   c. Establish time frame (maximum three years).

   d. Indicate person responsible for implementation of the plan.

   e. Seek assistance of handicapped individuals or organizations in developing this plan.

   f. Maintain copy of plan for public inspection.

JDB:sm

State of Alabama
Medical Services Administration

2500 Fairlane Drive
Montgomery, Alabama 36130

JACK E. WORTHINGTON
Commissioner

REBECCA B. BEASLEY
Confidential Assistant

ROBERT H. HOLZWORTH, M.D.
Chief of Medical Services

JACK W. GWIN
Medical Services Administrator

January 31, 1978

M E M O R A N D U M

TO: MSA Supervisors

FROM: Jack E. Worthington, Commissioner
Medical Assistance

SUBJECT: Affirmative Action Plan

Attached is a copy of MSA's Affirmative Action Plan for you to review and be certain that each employee under your supervision has an opportunity to review same.

In compliance with the Grievance Procedure, the following employees have been selected to serve a one-year term on the Grievance Committee and are being notified of the appointment.

Jim Harris, Chairman
Helen Wylie, Member
Charles Wilbanks, Member
Gloria Brown, Member
Marge Kennedy, Member
Nan Hornady, Member
Greg Morrison, Member

A forum is scheduled for February 3, at 9:00 a.m. in the MSA Conference Room for the purpose of allowing employees to ask questions about or provide input to the Plan.

Your assistance and cooperation in insuring that each MSA employee under your supervision has the opportunity to review the Plan and attend the forum, if the employee so desires, is appreciated.

JEW/JS/pcp

Attachment: Affirmative Action Plan

10-1-78

State of Alabama
Medical Services Administration

2500 Fairlane Drive
Montgomery, Alabama 36130

JACK E. WORTHINGTON
Commissioner

REBECCA B. BEASLEY
Confidential Assistant

ROBERT H. HOLZWORTH, M.D.
Chief of Medical Services

JACK W. GWIN
Medical Services Administrator

January 31, 1978

M E M O R A N D U M

TO: Jim Harris, Chairman
Helen Wylie, Member
Charles Wilbanks, Member
Gloria Brown, Member
Marge Kennedy, Member
Nan Hornady, Member
Greg Morrison, Member

FROM: Jack E. Worthington, Commissioner
Medical Assistance

SUBJECT: MSA Grievance Committee

In compliance with MSA's Affirmative Action Plan, the Grievance Committee has been selected and this will serve as your official notification of appointment to serve a term of one year.

Mr. Jim Harris is appointed to serve as Chairman of the Grievance Committee. Mr. Harris's appointment is also for the length of one year.

A copy of the Affirmative Action Plan along with the Grievance Procedure is attached for your review. The Chairman will schedule an organizational meeting soon.

A question and answer forum is scheduled for 9:00 a.m. on February 3, in the MSA Conference Room. Should you have questions about or input to the Affirmative Action Plan, please attend the forum so the matter can be discussed at that time.

JEW/JS/pcp

Attachment: Affirmative Action Plan

cc: Mr. Jack Gwin

10-1-77

State of Alabama
MEDICAL SERVICES ADMINISTRATION
2500 Fairlane Drive
Montgomery, Alabama 36130

NOTICE TO MEDICAID EMPLOYEES

July 19, 1977

The Rehabilitation Act of 1973 provides that no person shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

It is the policy of the Medical Services Administration, State of Alabama, that the recruiting, employment, and personnel administrative practices will be conducted in compliance with this law.

Jack E. Worthington

Jack E. Worthington, Commissioner
Medical Assistance

Rec'd 10/18/77 CFC-11 # 77-6 10/21/77
AS 12/26 eff 10/1/77

Medical Services Administration
Montgomery, Alabama

ALABAMA MEDICAID REGULATIONS 78-1

Section I - Purpose and Content 78-1

1. Introduction. ALABAMA MEDICAID REGULATIONS 78-1 supersedes Alabama Medicaid Letters 77-1 and 77-2, which should be destroyed. This edition composed of fifteen (15) sections, is being distributed to County Departments of Pensions and Security, Social Security Administration Offices, MSA Eligibility Section District Offices, and to all groups enumerated in paragraph 3, Format for Alabama Medicaid Regulations. Subsequent regulations which may alter or cancel data contained in these regulations will be designed to refer to specific paragraphs herein. They will be identified so that they may be placed in the appropriate section of the series; however, distribution will be limited to groups having a specific interest in the subject matter. Recipients of the ALABAMA MEDICAID REGULATIONS are urged to maintain them in a loose-leaf book so that they may be readily available for reference.

2. Purpose. The ALABAMA MEDICAID REGULATIONS series will be both informative and directive. Content may explain and/or expand other documents such as the Alabama Medicaid Plan, Contracts, and Agreements. They, along with Special Alabama Medicaid Information Regulations, may also pass on information received from Federal and State governmental agencies and report Medicaid contracts or actions which are of interest to the providers of medical services.

3. Format for Alabama Medicaid Regulations.

Section	Pertaining To	Serial Number	Distribution
I	Purpose and Content	78-	All Recipients of Alabama Medicaid Regulations
II	General & Miscellaneous	78-	All Recipients of Alabama Medicaid Regulations
III	Physicians	78-	Physicians & Association
IV	Long Term Care	78-	Skilled Nursing & Intermediate Care Homes & Association
V	Pharmaceutical Services	78-	Pharmacies & Association
VI	Eye Care Services	78-	Ophthalmologists, Optometrists, Opticians and Providers of Eyeglasses
VII	Home Health Care	78-	Home Health Care Agencies
VIII	Screening, Diagnosis & Treatment for Individuals Under Twenty-One (21)	78-	Special list & County Health Departments
IX	Hospitals	78-	Hospitals & Association
X	Dental Services	78-	Special list, County Health Departments & Dentists
XI	Hearing Aids	78-	Special list, County Health Departments & Approved Providers.

XII	Family Planning		., County Health [illegible] & Statewide Family Planning Project
XIII	Transportation Services	78-	[illegible]ion Providers
XIV	Third Party Determinations	78-	[illegible] Recipients of Alabama Medicaid Regulations
XV	Laboratory and X-Ray	78-	Physicians, Laboratories, Hospitals

4. The Title XIX (Medicaid) Plan for Alabama is the basic document for the Medicaid Program. It will be revised from time to time. It is expected that each revision will completely supersede the specific items in the prior plan because the plan must have received the approval of higher authority before being placed in force. The plan will be given a limited distribution, and persons not receiving copies may always see a copy at the offices of the Medical Services Administration, 2500 Fairlane Drive, Montgomery, Alabama 36130.

5. Federal and State Law Applicable to Medicaid. Reference should be made to the State Plan for details. Title XIX of the Social Security Act is the basic law establishing the Medicaid Program. Executive Order Number 51, dated June 16, 1977, signed by the Governor of the State of Alabama designates the Governor's Office as the single State agency to develop and administer the Medicaid Program in the State.

6. Management Agencies of the Program.

   a. The Medical Services Administration (MSA) is the operational unit for the Medicaid Program. All major policy decisions are approved by the Governor's Office.

   b. Agencies responsible for determining Medicaid eligibility are the Department of Pensions and Security, the Social Security Administration, and District Offices of Medical Services Administration. The names of eligible individuals and other pertinent data are certified to Medical Services Administration which makes the information available to the fiscal intermediaries to be used in connection with the payment of claims. Areas of responsibility for Medicaid eligibility determination are shown below:

      (1) Social Security Administration

         (a) This Federal agency is responsible for the Supplemental Security Income (SSI) Program which is for the aged, blind and disabled. When that agency determines a person to be eligible for SSI, the individual is automatically eligible for Medicaid. Questions about eligibility for the SSI program should be referred to the nearest Social Security Administration Office.

         (b) SSI eligibles will receive a Medicaid number consisting of thirteen (13) digits beginning with "000." The first twelve (12) digits are located at the top of the white, paper Medicaid Eligibility Card on the line designated "Medicaid Number"; the thirteenth digit is located in the "SUFFIX" column across from

MEDICAID MONTHLY ELIGIBILITY CARD

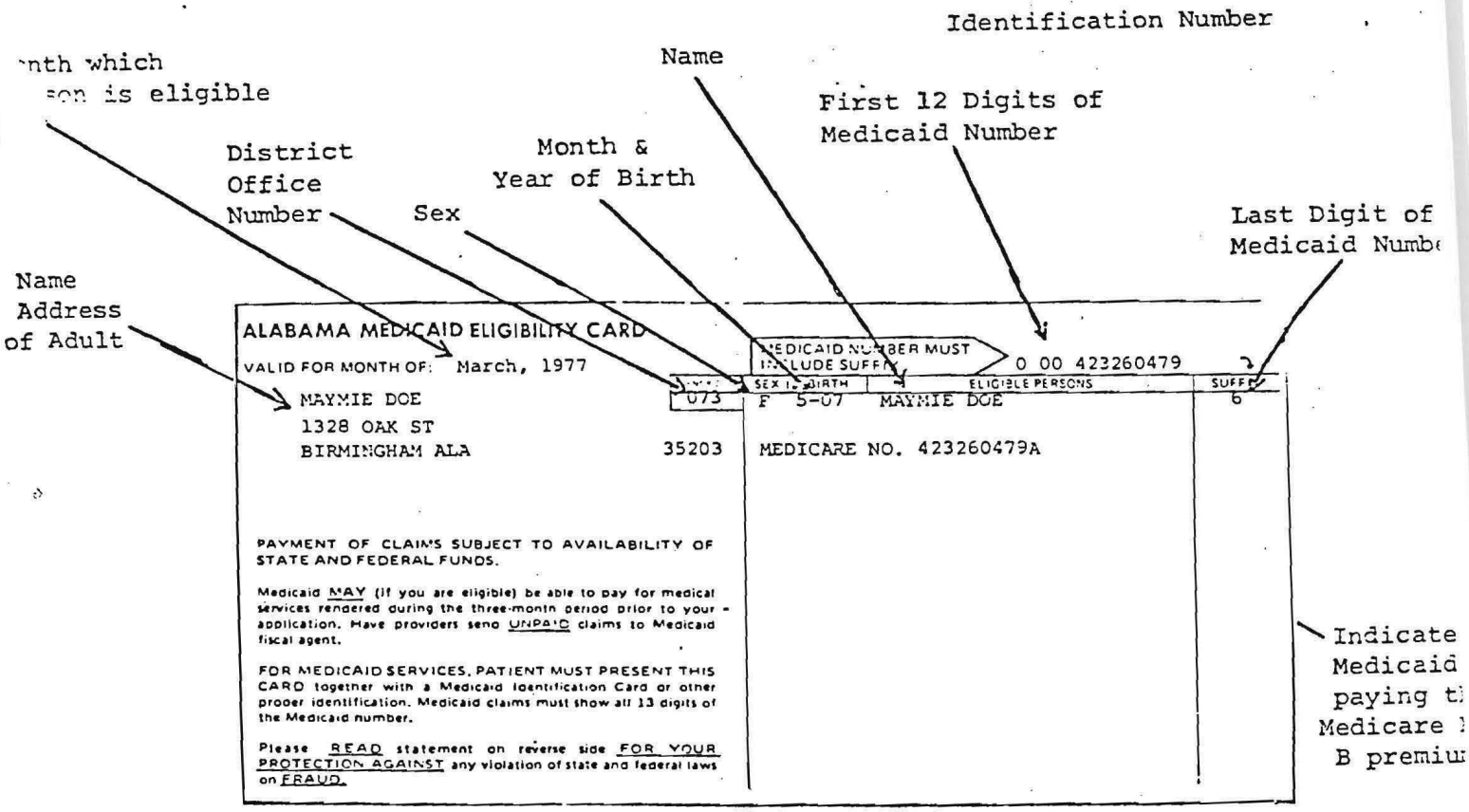


Figure 1

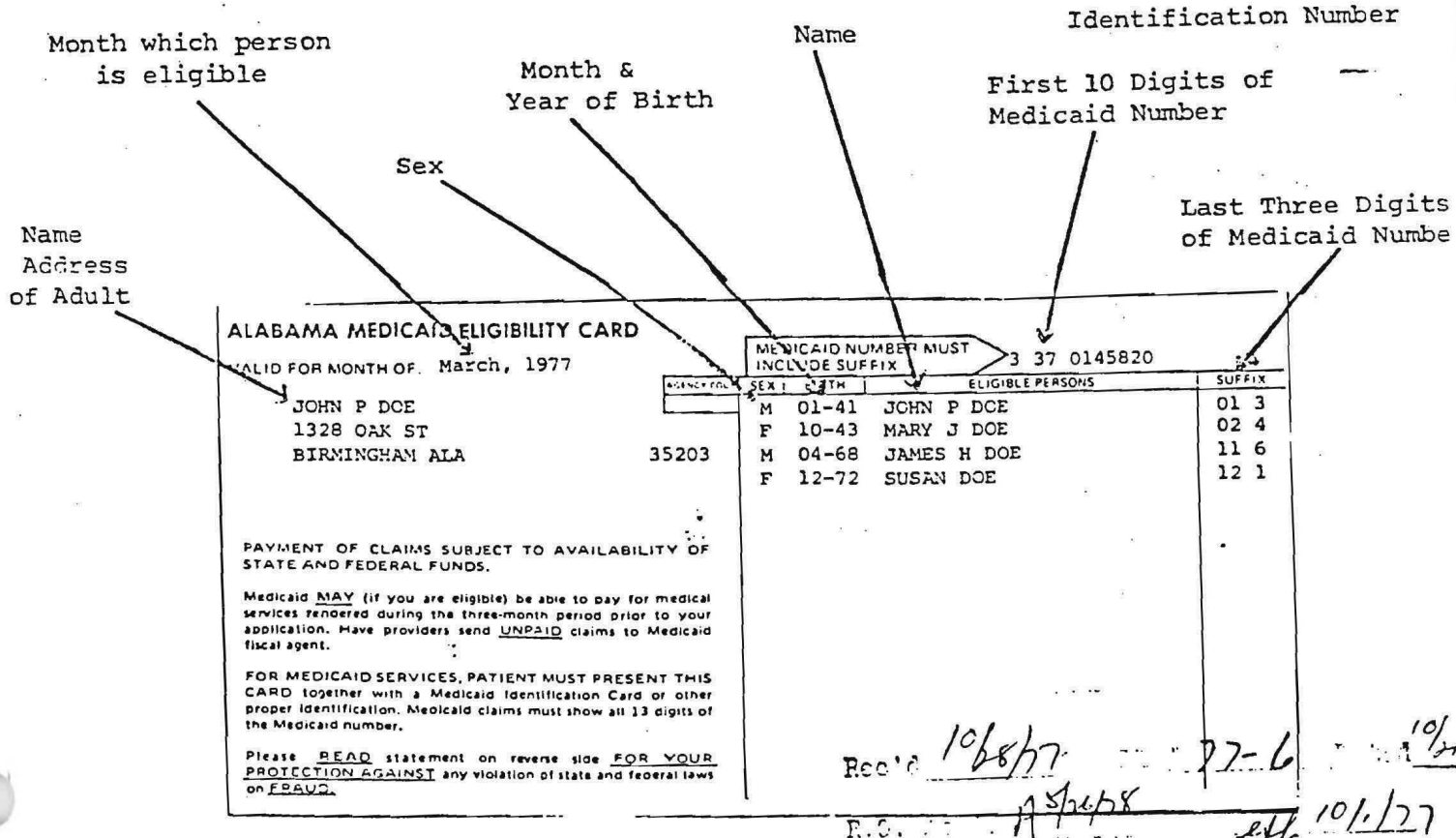
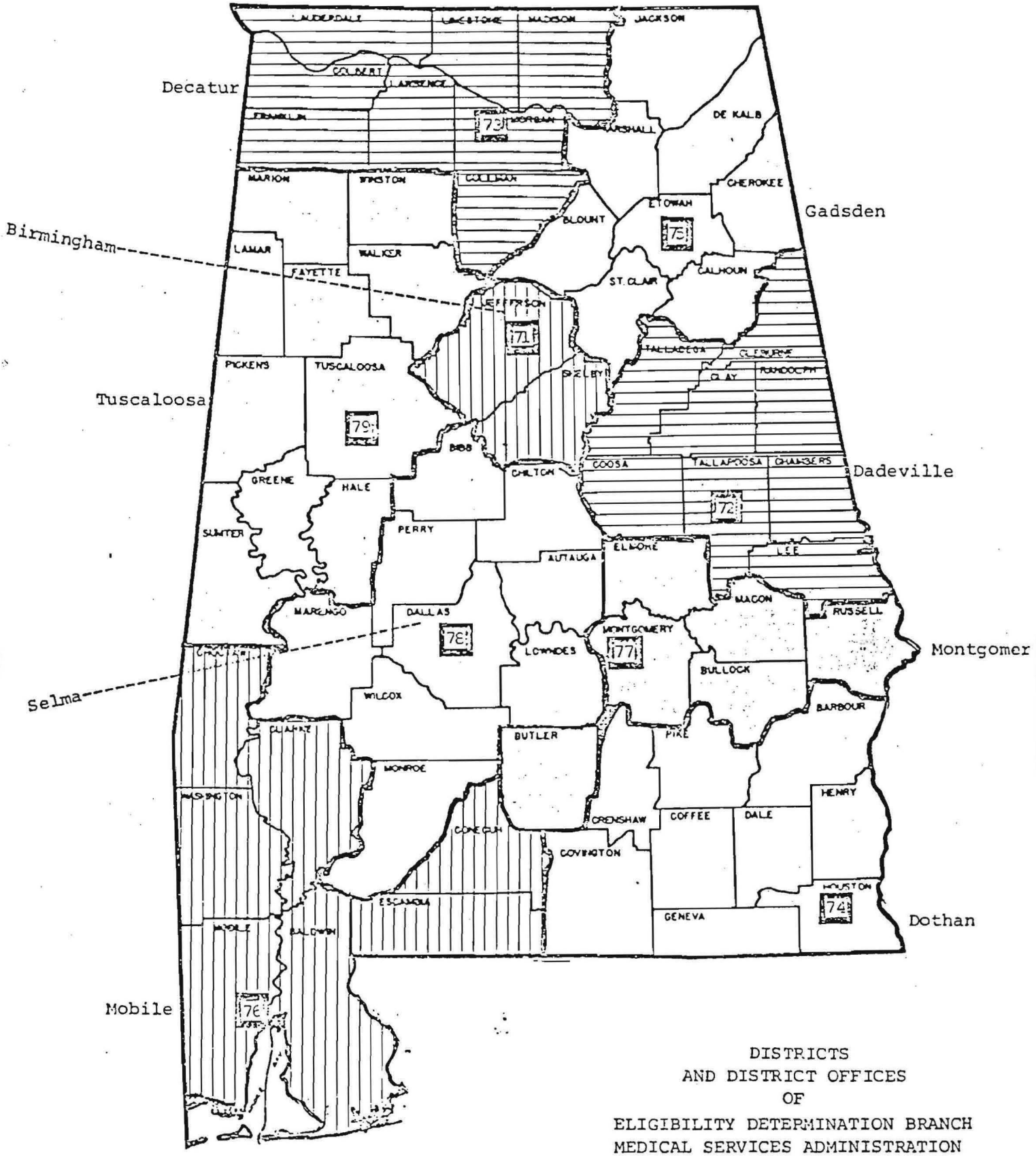


Figure 2



DISTRICTS
AND DISTRICT OFFICES
OF
ELIGIBILITY DETERMINATION BRANCH
MEDICAL SERVICES ADMINISTRATION

Rev'd 10/28/77 -- 77-6 Dated 10/31/77
Eff. 11/1/77

name of the eligible person. See Figure 1 on Page I-3, "Medicaid Monthly Eligibility Card."

(2) The Department of Pensions and Security

(a) The Department of Pensions and Security is responsible for making Medicaid eligibility determinations for certain authorized groups not eligible for SSI. Eligibility for groups services by the Department of Pensions and Security will be made in the County Departments.

(b) Persons in the groups mentioned below will have the same type of thirteen-digit Medicaid Identification Number in effect prior to January 1, 1974. The first ten (10) digits will appear on the white, paper Medicaid Eligibility Card in the space designated "MEDICAID NUMBER;" the last three (3) digits are located in the "SUFFIX" column following the recipient's name. See Figure 2 on Page I-3, "Medicaid Monthly Eligibility Card."

1 Individuals eligible for Aid to Families with Dependent Children.

2 All persons between eighteen (18) and twenty-one (21) years of age who would be eligible for Aid to Families with Dependent Children except for age and school attendance or failure to register for the Work Incentive Program.

3 All individuals who are eligible, under standards in effect in August 1972, to receive cash assistance under a State public assistance program, except for an increase in income resulting solely from the twenty (20) percent increase in Social Security monthly benefits enacted under Public Law 92-336. These individuals will remain eligible if they continue to meet those standards except for the twenty (20) percent increase in income.

4 Those persons not eligible for Supplemental Security Income who, on December 31, 1973, were in a medical institution, as long as there is a continuing need for the care for the condition for which they were institutionalized and as long as they continue to receive a money payment and meet the standards for financial assistance under an approved State Plan that were in effect on December 31, 1973.

(3) Medical Services Administration, Eligibility Determination Branch, District Offices - Persons in this group have a Medicaid number identical to that of an SSI recipient except that the agency code shown on the Medicaid card has the district office number in the block labeled "Agency Code" (see Page I-3).

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Obsolete Pg

(a) Individuals who would be eligible for Supplemental Security Income except for the fact that they are residents of a medical institution for a minimum of thirty (30) consecutive days and have an income of forty-five dollars ($45.00) or more but not to exceed three hundred thirty-six dollars ($336.00) per month. (In reality most people with income not in excess of three hundred fifty-six dollars ($356.00) would be eligible because most people are entitled to a twenty dollar ($20.00) general income exclusion.)

(b) Three-months-prior-to-application for persons on SSI.

(c) All blind, disabled, and aged who are not eligible for Supplemental Security Income who receive a State Supplement from the Department of Pensions and Security under standards of an approved State Plan in effect on December 31, 1973, AND who meet the SSI resource criteria as determined by the District Office.

(d) All individuals who were eligible for SSI on July, 1977, except for the Social Security cost-of-living increase are certified eligible for Medicaid if they continue to meet SSI standards except for the Social Security cost-of-living increase.

(e) Those persons in a nursing home not eligible for Supplemental Security Income and no longer entitled to a DPS money payment, who, on December 31, 1973, were eligible for aid through the Department of Pensions and Security and have continued to meet all December 31, 1973, eligibility criteria have been Grandfathered and, effective January 1, 1978, will be serviced by District Offices.

c. The Bureau of Licensure and Certification of the Department of Public Health is responsible for licensing hospitals, skilled nursing facilities, intermediate care facilities and other health facilities. This Bureau also certifies certain of these and other health facilities for participation in the Medicaid Program.

7. Fiscal Intermediary. The State agency for administering the Medicaid Program has entered into a contract with Blue Cross and Blue Shield of Alabama, 930 South 20th Street, Birmingham, Alabama 35298, to pay all claims for medical care and services authorized under the Plan.

8. Claims Communication. Providers having questions about their Explanation of Payment, remittance check, or other reimbursement problem should contact the Fiscal Intermediary in writing or by telephone.

a. Providers in the Birmingham area should telephone 252-9541. All other providers should use the toll-free number 1-800-292-4015, Extension 400.

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b. Questions relating to specific claims, adjustments, or refund activity should be recorded on a Medicaid Claim Inquiry Form (MCD-27). This form should be forwarded to Blue Cross and Blue Shield of Alabama, Medicaid Department, 930 South 20th Street, Birmingham, Alabama 35298.

9. Compliance with Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. In accordance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, no individual shall, on the ground of race, color, national origin, sex, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity receiving Federal financial assistance. It is the policy of Medical Services Administration to comply with the Civil Rights Laws and full cooperation from all providers is expected in the provision of Medicaid services. Complaints should be directed to the Commissioner, Medical Assistance, 2500 Fairlane Drive, Montgomery, Alabama 36130.

Jack E. Worthington

Jack E. Worthington, Commissioner
Medical Assistance

Rec'd 10/28/77 77-6 10/21/77
E.C. 11/4/78 11/1/77
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AGREEMENT
Between
MEDICAL SERVICES ADMINISTRATION
And
BUREAU OF MATERNAL AND CHILD HEALTH
ALABAMA DEPARTMENT OF PUBLIC HEALTH

In accordance with the terms of this Agreement, the Bureau of Maternal and Child Health, Alabama Department of Public Health, will provide prenatal care through appropriate county health departments or Title V agencies to persons who seek such services and who are eligible for Medicaid benefits under the Alabama State Plan for Medical Assistance, Title XIX of the Social Security Act.

I. Eligibility

1. Eligible individuals are those persons who are certified by Medical Services Administration as eligible for Medicaid benefits. It is understood that eligibility for Medicaid benefits may be terminated at the end of any calendar month.

2. It is incumbent upon the county health departments or Title V agencies to check a person's Medicaid eligibility at the time of each visit for prenatal care. It is understood that if a person is not eligible for Medicaid benefits at the time a service is rendered, payment will not be made by Medical Services Administration for any service provided on that visit.

II. Claims

Claims will be submitted at timely intervals (within 90 days) and in a format specified by Medical Services Administration, by the county health department or Title V agency providing the service directly to the designated fiscal intermediary. In the event of failure to submit claims within 90 days, a letter of justification must accompany the claim.

III. Arrangements for the Provision of Services

The Bureau of Maternal and Child Health will, through written agreements, sub-contract with county health departments or Title V agencies to provide prenatal care to Medicaid eligible persons. All such agreements will cover at least the following items, and will be subject to approval by Medical Services Administration.

1. Prenatal care will be provided by or under the supervision of a physician.
2. The county health department or Title V agency will have specific arrangements for referral of complicated cases that cannot be adequately handled by the county health department or Title V Agency to hospitals, medical facilities, or private physicians. Applicable portions of patient's records will be available upon request by referred agency if needed.
3. The county health department or Title V agency will have arrangements for referral of patients for delivery to the nearest professionally qualified and equipped hospital of patient's and physician's choice to render care for referral diagnosis. Patient's desire must be considered, but must fit guidelines of the nearest hospital designation. Patient's record will be transferred to the hospital to which the patient is referred.

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4. The county health department or Title V agency will provide post partum checkups of post partum patients and make appropriate referrals for follow-up on any medical problems identified.

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IV. Arrangements for Reimbursement

Medical Services Administration (MSA) through its fiscal agent, will reimburse the Bureau of Maternal and Child Health on a per visit rate, of $10.00.

1. Reimbursement will be made by Medical Services Administration only if both of the following conditions are met by each of the sub-contracting county health departments or Title V agencies:

   A. Each individual served under the prenatal and post partum care program is asked if she has third party benefits for maternity services; and

   B. All third party payers must be identified for reimbursable maternity services.

2. Payment to other Medicaid providers (physician) by Medical Services Administration is as follows:

   the rate of payment per visit will be the reasonable and customary physician's charge, or the prevailing rate in the area, whichever is applicable. Prenatal services paid to clinics cannot be included in the delivery fee.

   A. Each individual served under the prenatal and post-partum care program shall be asked if she has third party benefits for maternity services; and

B. All third party payers must be identified on the claim form for reimbursable maternity services.

V. Arrangements for Freedom of Choice

Each sub-contracting county health department or Title V agency shall agree to inform Medicaid eligible persons that they may receive this service from a private physician of their choice under the Medicaid Program. The fact that such information was given will be documented in the Medicaid patient's medical file.

VI. Other Provisions of this Agreement

The Bureau of Maternal and Child Health agrees that each sub-contracting county health department or Title V agency shall be required to:

1. Keep such records as are necessary to fully disclose the extent of services provided to eligible individuals and furnish the Medical Services Administration or its duly authorized agents with such information regarding payments claimed as may be required from time to time. All records shall be kept for a period of at least three years plus one month, following the last day of the fiscal year in which services were rendered unless a prior release date is authorized by Medical Services Administration.

2. Allow free access by duly authorized representatives of the State of Alabama, and Department of Health, Education, and Welfare (HEW), to its records pertinent to the Alabama Medicaid Program.

3. Inform all physicians to whom patients are referred for delivery that Medicaid will pay only for services rendered in connection

with the delivery itself, and that no payment will be made for prenatal or routine post partum checkups.

Comply with the Civil Rights Act of 1964, and with Section 504 of the Rehabilitation Act of 1973, in the execution of the provisions under this Agreement

Effective October 1, 1980

II. In accordance with the terms of the approved agreement between the Bureau of Maternal and Child Health/Family Planning and Medical Services Administration, the Alabama Department of Public Health, shall continue to provide prenatal care through appropriate county health departments or Title V agencies to persons who seek such services and who are eligible for Medicaid benefits under Alabama State Plan for Medical Assistance, Title XIX of the Social Security Act.

It is mutually agreed by the Bureau of Maternal and Child Health/Family Planning and Medical Services Administration that all terms and conditions contained in the approved master contract for prenatal services be extended effective October 1, 1980 through September 30, 1981, and shall continue from year to year, thereafter, unless cancelled by either party at any time upon written notice to the other party at least thirty (30) days prior to any termination date.

III. Amendment of this Agreement

The Agreement may be amended by written agreement duly executed by Medical Services Administration and the Bureau of Maternal and Child Health. It is mutually agreed that no alteration or variation of the terms of this Agreement shall be valid unless made in writing and duly signed by the parties hereto, and it is further agreed that no oral understanding or agreements not incorporated herein and alteration or variation of the terms hereof shall be binding on any of the parties hereto unless so made in writing between the parties. In addition, every such amendment shall specify the date its provisions shall be effective as agreed to by the parties.

IX. All provisions of this Agreement are subject to availability of Medical Services Administration funds (State and Federal) for the Medicaid Program.

IN WITNESS WHEREOF, the parties Hereto have caused this Agreement to be duly executed on this 5th day of August, 1980.

BUREAU OF MATERNAL AND CHILD HEALTH/
FAMILY PLANNING
ALABAMA DEPARTMENT OF PUBLIC HEALTH

By: Robert L. Cobb

Title: Director, Bureau of Maternal and Child Health/Family Planning

Date: 7/24/80

APPROVED:

Ira L. Myers, M.D./ Health Officer

Date: July-28, 1980

LEGAL DIVISION
Department of Finance
Approved by

MEDICAL SERVICES ADMINISTRATION
AN AGENCY OF THE STATE OF ALABAMA

By:

Date: 8/6/80

APPROVED:

Finance Director
State of Alabama

Date:

APPROVED:

Honorable Fob James, Governor
State of Alabama

Date:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Alabama

Liens and Recoveries

Citation

FR 43647,
October 1, 1982
42 CFR 433.36
AT-82-29

(a) The process by which the State will determine that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution (SNF or ICF) and return home will be based on the following:

(1) The agency will notify the individual through a written notice which explains what is meant by the term "lien," and that imposing a lien does not mean that the individual will lose ownership of the home. The notice explains by whom and on what basis the determination that the individual cannot reasonably be expected to be discharged from the institution will be made. (The determination process is herein after described).

Information concerning the process by which an individual will be given the opportunity for a hearing is provided through the aforementioned notice, and through a written Notice of Action (which notice will be sent at least ten days in advance of the date of action). These written notices inform the applicant/recipient in writing of his right to a hearing; of the method by which he may obtain a hearing; that he may represent himself or use legal counsel, a relative, a friend or other spokesman. These written notices inform the applicant/recipient that the agency will grant an opportunity for a hearing to any applicant/recipient or his legally appointed representative

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Alabama

Liens and Recoveries

Citation	
FR 43647, October 1, 1982 42 CFR 433.36 AT-82-29	or other authorized person who files a written request within 60 days following the action with which he is dissatisfied. These written notices inform the applicant/recipient that benefits may continue pending the outcome of the hearing unless there are unnecessary delays by the person or his representative when a hearing is requested within 10 days from the date of the action. The request for the hearing may be dismissed if the applicant/recipient withdraws the request in writing; or the applicant/recipient fails to appear at a scheduled hearing without good cause. Upon receipt of the written request, the hearing is scheduled for a reasonable date, time and place. At least 10 days advance notice of the hearing date will be given. The applicant/recipient, or his representative is informed in writing of the opportunity to examine the content of the applicant or recipient's case file, and all documents and records to be used by the state or local agency at the hearing, bring witnesses, establish all pertinent facts and circumstances, present an argument without undue interference, and question or rebut any testimony or evidence, including

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Alabama

Liens and Recoveries

Citation

FR 43647,
October 1, 1982
42 CFR 433.36
AT-82-29

opportunity to confront and cross-examine adverse witnesses.

(2) The process by which the state agency will determine that an individual cannot reasonably be expected to be discharged from the medical facility (SNF or ICF) is as follows.

The agency will send a form to the individual's personal physician requesting the physician's opinion, based on his/her medical condition, as to the individual's actual probability of permanent institutionalization. That form will also request the physician's opinion as to whether the individual can reasonably be expected to be discharged from the nursing facility and return home. That form will also ask the physician to support his/her opinion with a statement of the individual's diagnosis, prognosis and other relevant medical data. The agency's initial determination will be based upon the physician's report.

If the physician's opinion is that the individual cannot reasonably be expected to be discharged and return home, then the Agency may require a lien from the individual. This individual will be notified in writing of this determination. If the

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Alabama

Liens and Recoveries

Citation

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AT-82-29

individual disagrees with this determination, he/she may submit to the agency any credible medical evidence that the individual can reasonably be expected to be discharged and return home, and it will be accepted and considered by the State Agency.

Further, an actual absence from the home will not be considered temporary if the individual has been in the institution for a period in excess of 12 months, although this is a rebuttable presumption.

Each case will be considered individually on its merits. Any adverse decision can be appealed through the State's fair hearing process as described herein above.

No liens or encumbrances of any kind are required from or imposed against the property of an individual because of Medicaid claims paid or to be paid on his or her behalf except as permitted under 42 CFR 433.36. The State may require a lien against the real property of an individual described in paragraphs B.2. and/or B.7. of Attachment 2.2-A of the State Plan who is a patient in a SNF or ICF, if the State has made a medical determination that the individual cannot reasonably be expected to be discharged from the facility and return home; and has determined that the applicant/

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Alabama

Liens and Recoveries

Citation

FR 43647,
October 1, 1982
42 CFR 433.36
AT-82-29

recipient has no spouse, child under age 21, blind or disabled child lawfully living in the home; and has determined that there is no sibling of the applicant/recipient with an equity interest in the house and who was residing in the home for at least one year immediately before the date the applicant/recipient was admitted to the medical institution, lawfully living in the home. See Attachment 2.6-A for Eligibility Conditions or Requirements. In any event no lien will be imposed or required except as allowed by §1917 of the Social Security Act, as implemented in 42 C.F.R. §433.36.

There is no adjustment or recovery of Medicaid claims correctly paid, except as permitted under 42 CFR 433.36.

(b) For the purpose of this rule:

(1) "Home" is defined as any shelter in which the individual (or spouse with whom the individual lives) has an estate or ownership interest and which is used by the individual (and spouse, if any), as his principal place of residence, and includes a mobile or modular home located on realty in which the individual has an estate or ownership interest. A home will be limited to the actual dwelling, plus any noncommercial outbuildings plus up to five contiguous acres as a curtilage.

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STATE Alabama

Liens and Recoveries

Citation

FR 43647,
October 1, 1982
42 CFR 433.36
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(2) "Equity interest in the home" is defined as any estate in real property which is cognizable under the laws of the State of Alabama in the homeplace under consideration.

(3) "Residing in the home for at least one (two) year(s)" refers to:

i. "A sibling of the applicant/recipient" (who is residing in the applicant's or recipient's home for at least one year immediately before the date of the applicant's/recipient's admission to the medical institution) is defined as one who is lawfully residing in the home on a continuous basis since the date of the individual's admission to the medical institution;

ii. "Son or daughter of the applicant/recipient" is defined as one who was residing in the home for at least two years immediately before the date the individual was admitted to the medical institution, who establishes to the satisfaction of the State that the care that he or she provided during these two years permitted the individual to live at home rather than in an institution and is one who is lawfully residing in the home on a continuous basis since the date of the individual's admission to the medical institution (SNF or ICF).

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FR 43647,
October 1, 1982
42 CFR 433.36
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(4) On a "continuing basis" is defined as lawfully residing in the applicant's/recipient's home with an absence from the home not to exceed seven days per calendar month since the date of the applicant's/recipient's admission to the medical institution. This "seven-day rule" is a rebuttable presumption. Exceptions for involuntary absences or clearly temporary absences will be considered on a case-by-case basis. Examples: an involuntary absence would be a stay in a hospital of over 7 days' duration; and a clearly temporary absence would be an absence of over 7 days' duration for a vacation or the like. Each absence of over 7 days' duration will be judged individually. Adverse decisions can be appealed through the State's fair hearing process (which is described hereinabove).

(5) "Discharge from the medical institution and return home" is defined as a discharge based on the approval of the attending physician in accordance with the discharge plan, and as actual residence at the home on which the lien was placed for at least 120 continuous hours following discharge from the medical institution.

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STATE Alabama

Liens and Recoveries

Citation

FR 43647,
October 1, 1982
42 CFR 433.36
AT-82-29

(6) "Lawfully residing" is defined as living in the home as the principal place of residence under a legal right to do so with the full knowledge and consent of the applicant/recipient.

(c) The State will foreclose upon a lien only when there is no spouse or child under age 21 (or blind or disabled) lawfully residing in the home; there is no sibling of the applicant/recipient who was residing in the applicant's/recipient's home at least one year immediately prior to the date of the applicant's/recipient's admission to the medical institution (SNF or ICF) and who is lawfully residing, in the home on a continuous basis since the date of the applicant's/recipient's admission to the medical institution; and there is no son or daughter of the applicant/recipient who was residing in the home for at least two years immediately prior to the date of the applicant's/recipient's admission to the medical institution, who establishes to the satisfaction of the State that the care that he or she provided during these two years permitted the applicant/recipient to live at home rather than in an institution, and who is lawfully residing in the home on a continuous basis since the date of the applicant's/recipient's admission to the medical institution.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Alabama

Liens and Recoveries

Citation	
FR 43647 October 1, 1982 42 CFR 433.36 AT-82-29	A son or daughter can establish to the agency's satisfaction that he or she has been providing care which permitted the individual to reside at home rather than in an institution (SNF or ICF) by providing the agency with convincing evidence that establishes that fact.

(7) The State defines "estate" as: An estate consists of real and personal property and other assets as defined by Alabama probate law.

(8) The State defines "undue hardship" as: The existence of a situation, established by convincing evidence, that the estate subject to recovery is an asset such as a family farm or family business which produces limited income and is the sole income-producing asset of one or more heirs to the estate. The State will waive recovery while such a situation exists. An undue hardship waiver is not available: (a) for individuals with long term care insurance policies who became Medicaid eligible by virtue of disregarding assets because of payments made by a long term care insurance policy or because of entitlement to receive benefits under a long term care insurance policy; or (b) where an individual has created the claimed hardship by resorting to estate planning methods under which the individual illegally divested assets in order to avoid estate recovery.

(9) The State defines "cost-effective" as: A situation where the State determines that the amount to be recovered exceeds the cost of recovery. The State will determine cost-effectiveness on a case-by-case basis, based on such factors as: the size of the estate; the amount of the State's claim; whether an estate has already been opened by an heir or other creditor; the expected amount of fees for appraisals, filings and other items; and other anticipated legal and administrative costs.

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

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905 (a) (1) through (5) and (7) of the Act and 42 CFR 447.53. Cost sharing may not be imposed for the services, items, and populations specified at sections 1916(a)(2) and (j) of the Social Security Act and 42 CFR 447.53(b).

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Prescribed Drugs (Eff. Date 7/1/13)			X	Medicaid eligibles shall pay the following copayment based on the recipients costs for each prescription and refill received under the Medicaid Program: Prescription Cost — Copay $10.00 or less — $ .65 10.01 to 25.00 — 1.30 25.01 to 50.00 — 2.60 50.01 or more — 3.90 The Agency copay amounts are in accordance with 42 CFR 447.54(a) and 447.54(c).
Inpatient Hospital Services including Crossover (Eff. Date 7/1/85)			X	Medicaid eligibles shall pay a $50.00 copayment for each inpatient hospital admission. This copayment is based on the average cost per day of care which is $311.50. Crossover claims shall be assessed a $50.00 copayment per claim. The Agency copay amounts are in accordance with 42 CFR 447.54(a) and 447.54(c).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Outpatient Hospital Services including crossovers (Effective Date 7/1/13)			X	Medicaid eligibles using a hospital outpatient facility on a non-emergency basis shall pay a three dollar and ninety cents ($3.90) copayment per visit. Crossovers are assessed a $3.90 copayment per claim. The Agency copay amounts are in accordance with 42 CFR 447.54(a) and 447.54(c)
Physician Services (office) including crossovers (Effective Date 7/1/13)			X	Copayment for physician office visits is applied based upon the allowed amount for each procedure code including crossover claims. The Agency copay amounts are in accordance with 42 CFR 447.54(a) and 447.54(c). The copayment amounts for physician office visits are as follows: $50.01 or more - $3.90 per visit, $25.01-$50.00 -$2.60 per visit, and $10.01-$25.00 - $1.30 per visit
Durable Medical Equipment Including crossovers (Effective Date 7/1/13)			X	Copayment for DME is applied based upon the allowed amount for each procedure code. The Agency copay amounts are in accordance with 42 CFR 447.54 and 447.55. The copayment amounts for DME are as follows: $50.01 or more - $3.90 per item, $25.01-$50.00 -$2.60 per item, and $10.01-$25.00 - $1.30 per item

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Medical Supplies including crossovers (Effective Date 7/1/13)			X	Copayment for medical supplies is based upon the allowed amount for each procedure code. The Agency copay amounts are in accordance with 42 CFR 447.54 and 447.55. The copayment amounts for medical supplies are as follows: $50.01 or more - $3.90 per item, $25.01-$50.00 -$2.60 per item, $10.01-$25.00 - $1.30 per item, and $10.00 or less - $0.65 per item.
Rural Health Clinic including crossovers (Effective Date 7/1/13)			X	Medicaid eligibles shall pay a three dollar and ninety cents ($3.90) copayment for each rural health encounter. Crossovers are assessed a $3.90 copayment. The Agency copay amounts are in accordance with 42 CFR 447.54(a) and 447.54(c).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Optometric Services including crossovers (Effective Date 7/1/13)			X	Copayment for optometric services is applied based upon the allowed amount for each procedure code including crossover claims. The Agency copay amounts are in accordance with 42 CFR 447.54 (a) and 447.54 (c). The copayment amounts for optometric services are as follows: $50.01 or more - $3.90 per visit, $25.01-$50.00 -$2.60 per visit, and $10.01-$25.00 - $1.30 per visit
Ambulatory Surgical Center Services (Effective Date 7/1/13)			X	Medicaid eligible persons using an ambulatory surgical center shall pay a three dollar and ninety cents ($3.90) copayment per visit. The Agency copay amounts are in accordance with 42 CFR 447.54(a) and 447.54(c). NOTE: No copayment authorized under this attachment 4.18-A shall exceed the maximum allowable charges as provided in Subpart A, 42 CFR 447.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Federally Qualified Health Centers including crossovers (Effective Date 7/1/13)			X	Medicaid eligible persons shall pay a three dollar and ninety cents $3.90 copayment for each medical clinic encounter. Crossovers are assessed a $3.90 copayment. The Agency copay amounts are in accordance with 42 CFR 447.54 (a) and 447.54 (c).
Certified Nurse Practitioner Services (Effective Date 7/01/13)			X	Copayment for nurse practitioner services is applied based upon the allowed amount for each procedure code including crossover claims. The Agency copay amounts are in accordance with 42 CFR 447.54(a) and 447.54(b). The copayment amounts for nurse practitioner services are as follows: $50.01 or more - $3.90 per visit, $25.01-$50.00 -$2.60 per visit, and $10.01-$25.00 - $1.30 per visit NOTE: No copayment authorized under this attachment 4.18-A shall exceed the maximum allowable charges as provided in Subpart A, 42 CFR 447.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State : Alabama

B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The ability of the recipient to pay copayment will be established on a basis of the following statewide policy:

Providers will ask the recipient "Do you have the ability to pay the co-pay amount?"

The recipient's response will be accepted as conclusive evidence of the ability to pay or not to pay. All providers will be notified of this policy thru a provider notice.

D. Program changes are made to MMIS system to exempt identified clients and services from cost sharing. For American Indians, we are currently exempting based on race code (I). Changes are being made to allow a value code to be placed on the claim form effective by the Provider of Services for those American Indians that present an Active User Letter. This system change should be effective no later than July 1, 2011. All providers are notified of exempted services through a provider notice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (includes due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

* Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

C. State or local funds under other programs are used to pay for premiums:

/ / Yes / / No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

* Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

C. State or local funds under other programs are used to pay for premiums:

/ / Yes / / No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment.

Enclosure 3

Attachment 4.19 A

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Approval Date _____ Plan # _____

Effective Date _____ Supersedes Plan # _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

I. GENERAL PRINCIPLES

Effective Date: 01/01/02

Inpatient reimbursement rates, including payment for psychiatric services for individuals under 21 and over 65 years of age, and for psychiatric residential treatment services for individuals under age 21, are calculated from cost reports filed in accordance with this plan. The rates will be the lesser of each facility's reasonable costs per day as determined by the method as outlined herein. Payment for transplant service is exempt from Sections I-VIII of this Plan (see Section XX).

II. DEFINITIONS

(a) Cost Report: A report which details, for purposes of Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicaid Uniform Cost Report contains the forms utilized in filing said cost report.

(b) Accrual Method of Accounting: For Medicaid cost reporting purposes, an allocating of revenues and expenses to the accounting period in which they are incurred. This must be done regardless of when cash is received or disbursed.

(c) Allowable Costs: Costs of services incurred by an efficiently and economically operated hospital which are not otherwise disallowed by the reimbursement principles established in Chapter 23 Hospital Reimbursement Program of the Alabama Medicaid Agency Administrative Code. These principles are a set of rules, regulations, laws, and interpretations which provide direction as to the allowability of costs incurred by hospitals for the inclusion of these costs in their prospective Medicaid inpatient reimbursement rates. These rules, regulations, laws, and interpretations are promulgated by the Alabama Medicaid Agency, and are, in part, based on generally accepted accounting principles and regulations required of the Alabama Medicaid Program by various federal and state laws and regulations.

(d) Reasonable Costs: Necessary and ordinary costs related to patient care which a prudent and cost-conscious hospital would pay for a given item or service.

(e) Educational Costs: Reasonable costs of approved educational programs of study which have been certified by an appropriate federal, state, or other regulatory body.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

(f) Costs Related to Capital Assets: For purposes of this plan, capital cost shall consist of the following:

1. Depreciation -
   Building and Fixed Equipment
   Major Moveable Equipment

2. Interest -
   Working Capital

(g) Low Occupancy Adjustment: An adjustment to be computed for those hospitals which fail to maintain the minimum level of occupancy of the total licensed beds. A 70% occupancy factor will apply to hospitals with 100 or fewer beds. An 80% occupancy factor will apply to hospitals with 101 or more beds. Such adjustment will be composed of the fixed cost associated with the excess unoccupied beds and shall be a reduction to Medicaid inpatient cost.

(h) Trend Factors: A statistical measure of the change in costs of goods and services purchased by a hospital during the course of one year. The trend factors to be used for purposes of this plan shall be computed based upon the economic indicators as published by Data Resources, Inc. (DRI).

(i) Patient Day: Any day that a bed is either occupied or reserved for a patient on an authorized and temporary leave of absence from the hospital. The midnight to midnight method must be used for Medicaid reporting purposes.

(j) Approved Capital Expenditure Project: A project for which a Certificate of Need has been issued by the State Health Planning Agency. Such a project may include expansions, renovations, and/or additions to an existing facility. Acquisition of an ongoing facility is not considered an approved capital expenditure project for purposes of revising per diem rates.

Medicaid reserves the right to decline reimbursement of depreciation and interest expense related to asset purchases not previously approved by Medicaid. In addition, Medicaid will not reimburse costs related to new patient care beds which would add to the licensed bed capacity constructed under certificates of need dated on or after October 1, 1983. With respect to replacement beds placed into service on or after October 1, 1983, the hospital must request, in advance of a Medicaid contract application, a determination from Medicaid as to whether the

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

depreciation, interest, and other capital-related costs of the beds may be included in allowable Medicaid cost. Such replacement beds must have a CON dated prior to October 1, 1983 for actual capital costs to be considered by Medicaid. In those situations regarding replacement bed construction under CONs dated after October 1, 1983, the Agency will continue to recognize allowable capital costs related to the assets before replacement construction. Replacement of equipment is not affected by this limitation.

Effective Date: 01/01/92

(k) Return on Equity Capital (applicable to proprietary hospitals only): An allowance to proprietary hospitals which is based upon a reasonable return on the invested equity capital related to the provision of necessary patient care. Such allowance shall be eliminated over a three year period. Beginning with the 7/1/88 rate period, payment will be 75% of the amount as normally calculated; 7/1/89, 50%; 7/1/90, 25%, and zero thereafter.

(l) Hospital Group: There are four groups of hospitals for Medicaid rate calculation purposes. The groups are as follows:

(1) Urban: Hospitals located within a Metropolitan Statistical Area (MSA) or the successor of such MSA as defined by the U. S. Bureau of Census.

Effective Date: 07/01/94

(a) Grouped According to Bed Size

0 - 100 licensed beds	Urban 1
101 - 250 licensed beds	Urban 2
251 - 500 licensed beds	Urban 3
501 + licensed beds	Urban 4

(2) Rural: Hospitals not located within an MSA or successor to an MSA.

(3) Unique or Specialized: Hospitals which provide unique or specialized services atypical to any group. Such classification shall be at the discretion of Medicaid. The criteria used by the Division of Licensure and Certification of the Alabama Health Department in licensing a hospital shall be considered by the Alabama Medicaid Agency in determining which hospitals should be classified as unique or specialized.

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

METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

II. DEFINITIONS (continued)

Effective Date: 10/01/2024

(m) Access Payment: A supplemental payment by the Medicaid program to an eligible hospital for inpatient and outpatient hospital care provided to a Medicaid recipient.

(n) Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2013, through September 30, 2025, 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.

(o) Medicare Cost Report: The electronic cost report (ECR) filing of the CMS Form -2552-96 and 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").

(p) Privately Owned and Operated Hospital: For purposes of Medicaid base per diem, supplemental and DSH payments, a hospital in Alabama other than:

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

(2) 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;

(3) 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, Chapter 51 of Title 22, or Chapter 95 of Title 11, or a hospital otherwise owned and operated by a unit of local government, Alabama Code of 1975 22-21-1.

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

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

(q) Non State Government Owned and Operated Hospital: For purposes of Medicaid base per diem payments, supplemental payments and DSH payments, a hospital in Alabama created or 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 or operated by a unit of local government pursuant to Alabama Code of 1975 22-21-1.

(r) State Owned or Operated Hospital: For purposes of Medicaid base per diem payments, quarterly adjustment and DSH payments, a hospital in Alabama that is a state agency or unit of state government, including without limitation a hospital owned or operated by a state agency or a state university.

(s) Rehab Hospitals and Long Term Acute care hospitals referenced in paragraph (p)(4) and (p)(5) above are not included in UPL or reimbursed by Medicaid for base payments, access payments under section 4.19-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 11/01/95

(4) Psychiatric hospitals: Psychiatric hospitals which are enrolled with Medicaid to provide inpatient psychiatric services to children under 21 years old and to adults who are over 65 years of age.

Effective Date: 01/01/92

III. PER DIEM RATE COMPUTATION

(a) The as-filed Medicaid FY cost report will be used to compute a hospital's per diem rate. The cost report shall be desk reviewed and any non reimbursable items will be removed from reported cost prior to calculating a rate.

(b) The per diem rates as calculated by the Alabama Medicaid Agency shall be provided to the hospitals prior to the effective date for their information and review.

(c) The total Medicaid cost from the cost report shall be adjusted as follows:

(1) The medical education cost per diem and the capital-related cost per diem are subtracted from the inpatient hospital cost per diem. The remaining cost per diem is separated into Administrative and General (A & G) and non- Administrative and General per diem components. The components will then be multiplied by the applicable hospital industry trend factor (as adjusted by any relevant trend factor variance). The resulting trended A & G cost per diem will be arrayed within hospital grouping in ascending order. The number of hospitals in each grouping will be multiplied by the applicable percentile to determine the position of the hospital that represents the appropriate percentile. That hospital's cost in each grouping will become the ceiling for that grouping. The ceiling or actual cost per day (whichever is less) will be the adjusted Administrative and General per diem cost. Add the adjusted (if applicable) A & G per diem component cost to the non-administrative per diem component cost.

(2) Capital-Related and Medical Education Costs Per Diem

(A) Adjust capital-related cost for all hospitals per diem be any applicable low occupancy cost per day. (Rural hospitals shall not be subject to a low occupancy adjustment.)

(B) Medical Education cost per diem will be multiplied by the hospital industry medical education costs trend factor.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 01/01/92

(3) The total Medicaid per diem cost per day, subject to the overall applicable percentile ceiling, shall consist of:

(A) Operating costs as adjusted in III(c)(1) above.

(B) Capital-related cost as determined in III(c)(2) above.

(C) Return on Equity per day, if applicable (for proprietary hospitals). Beginning with the 7/1/88 rate period, payment will be 75% of the amount as normally calculated; 7/1/89, 50%; 7/1/90, 25%, and zero thereafter.

Effective Date: 07/01/94

(4) The total Medicaid costs per day as determined in III.(c)(3) shall be separated into the applicable hospital groupings. Within the grouping, the total cost per day will be arrayed in ascending order. The number of hospitals in each grouping will be multiplied by the applicable percentile to determine the position of the hospital that represents the appropriate percentile. That hospital's cost in each grouping will be the ceiling for that grouping. Hospitals determined to be unique or rural by the Agency are not subject to these ceilings. Urban I hospitals shall be subject to a 90th percentile ceiling. Urban II, III, and IV hospitals shall be subject to an 80th percentile ceiling. Psychiatric hospitals shall be subject to a 60th percentile ceiling.

(5) The lesser of the above-determined ceiling or actual cost per day shall be added to any applicable education cost as adjusted in III(c)(2)(B). The sum shall be a hospital's Medicaid per diem rate for the new period.

(d) The projected trend factor shall be computed on an annual basis and applied to those costs subject to the factor from the mid-point of the hospital's cost report period to the mid-point of the rate period. Adjustments to the trend factor (trend factor variances) shall be calculated as follows:

(1) Adjustments shall be made only for variations from the projected to the actual of greater than one-half of one percent in either direction.

(2) These adjustments shall be made on a prospective basis and shall become a part of the trend factor for the current rate period.

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METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

(e) Adjustments to Rates: The prospectively determined individual hospital's reimbursement rate may be adjusted as deemed necessary by the Agency. Circumstances which may warrant an adjustment include, but are not limited, to:

(1) A previously submitted and/or settled cost report is corrected. If an increase or decrease in rate results, any retroactive adjustments shall be applied as of the effective date of the original rate. Any such payment or recoupment will be made in the form of a lump sum amount and/or a rate change.

(2) The information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. This may be considered grounds to suspend the hospital from participation in the Alabama Medicaid Program.

(3) The hospital experiences extraordinary circumstances which may include, but are not limited to, an Act of God, war, or civil disturbance. Adjustments to reimbursement rates may be made in these and related circumstances.

(4) Under no circumstances shall adjustments resulting from paragraphs (1)-(3) above exceed the group ceiling established. However, if adjustments as specified in (1) through (3) so warrant, Medicaid may recompute the group ceiling.

Effective Date: 10/01/95

(f) Prepaid Health Plan (PHP):

(1) As an alternative to paying a per diem rate to each hospital for inpatient services; hospitals, except for psychiatric hospitals which will continue to be paid fee-for-service, in contiguous counties in a geographical area will form an organization or entity, i.e., a Prepaid Health Plan (PHP) prior to October 1, 1995. The incentive for hospitals to participate in the PHP is the same as other capitation payment systems. The hospitals can eliminate duplica-tion of services and coordinate care. They benefit by cutting costs and coming in under the capitation rate. The PHP would contract with the Alabama Medicaid Agency to provide inpatient hospital services to Medicaid eligibles residing in the PHP's geographic area under a capitated payment arrangement. The PHP will be activated according to the beginning date on its signed contract. The contract between Medicaid and the PHP will require that the PHP pay all hospitals the cost on an efficiently and

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

economically operated level. Medicaid patients do not lose freedom of choice; however, the networks should structure services to encourage patients to stay within the network. If a patient goes to a hospital outside the network, the network in which the patient resides will pay for the inpatient services. The payment rate would be as described in Section III, pages 4-6 of attachment 4.19-A which will still be calculated by the Alabama Medicaid Agency for all hospitals in the Medicaid Program. Claims for inpatient services will be processed by the Alabama Medicaid Agency and they will generate zero paid Explanation of Payments to the network so they can make payment to the individual hospitals. The PHP will be required to pay rates to all in-state hospitals using identical methodology for hospitals in or out of the PHP. The claims for inpatient services would continue to be processed through the Alabama Medicaid Agency programs for any benefit limitations and for gathering of Medicaid statistical data. The disproportionate share payments for the hospitals in the PHP would be added to the capitated payments.

(2) Capitation Rate Methodology:

(a) The capitated rate would be as follows:

$$\frac{\text{Historical Cost (2)(b)(1)}}{\text{Eligible Months (2)(b)(2)}} = \text{Payment Per Member Per Month}$$

(b) The capitation rate methodology will be as follows:

1. The Alabama Medicaid Agency historical inpatient hospital costs will be obtained from Alabama Medicaid paid claims listing for all of the participating hospitals in each geographic PHP. The base period will be July 1, 1993, through June 30, 1994. Base period cost will be trended to current year based upon the economic indicators as published in Health Care Costs by DRI/McGraw-Hill as is the current methodology.

2. Eligible months is defined as the total number of months Medicaid only recipients were certified for Alabama Medicaid eligibility for the base period of July 1, 1993, through June 30, 1994, which will be updated annually, excluding SOBRA adults in maternity waiver counties and Part A Medicare eligibles.

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STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

(3) Disproportionate share hospitals payment: The sum of the disproportionate share payments that would be payable to the individual hospitals that are members of the PHP, not to exceed the amount allowed under OBRA '93.

(4) Payments:

(a) The PHP would receive a monthly capitated payment for each eligible, plus the PHP disproportionate share payment.

(b) Alabama Medicaid shall not pay a PHP more for inpatient hospital services under a capitation rate than the cost of providing those services under the regular inpatient hospital payment methodology.

(c) Capitation payments to the plan for all eligible enrollees shall be made monthly. The PHP will receive the monthly capitated payment for each member regardless of utilization of PHP inpatient hospital services as indicated in the capitation rate methodology. The capitation rates are determined using historical costs and historical utilization. They do not exceed Medicare upper limits; therefore, the capitation payments should not exceed Medicare upper limits.

(d) Payments described in Section III,(h), pages 6C and 6D of Attachment 4.19-A will be paid directly to the appropriate hospitals as defined in Section III (h).

(5) Should Medicaid not contract with a PHP, Medicaid will continue paying those hospitals that are not members of a PHP using present per diem methodology on a fee for service basis.

Effective Date: 06/10/87

(g) Inpatient and outpatient retroactive settlements on amended Medicare/Medicaid cost reports with fiscal years ending prior to October 1, 1984, will no longer be processed for payment by or to the Alabama Medicaid Agency.

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METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 11/01/95

(h) As an alternative, for the period October 1, 1995 through September 30, 1996, each hospital shall receive a per diem payment and a disproportionate share payment. The sum of such payments, at each hospital, shall not exceed:

HOS0001H	SOUTHEAST ALABAMA M.C.	13,013,079
HOS0004H	NORTH JACKSON HOSPITAL	1,065,770
HOS0005H	BOAZ - ALBERTVILLE M.	4,947,408
HOS0006H	ELIZA COFFEE MEMORIAL	10,650,074
HOS0007H	MIZELL MEMORIAL HOSPITAL	539,571
HOS0008H	CRENSHAW BAPTIST HOSPITAL	1,087,039
HOS0009H	HARTSELLE MEDICAL CENTER	136,495
HOS0010H	GUNTERSVILLE - ARAB M.C.	2,143,710
HOS0011H	MEDICAL CENTER EAST	1,773,877
HOS0012H	DEKALB BAPTIST M.C.	1,698,462
HOS0015H	THOMASVILLE HOSPITAL	234,530
HOS0016H	SHELBY MEDICAL CENTER	9,029,201
HOS0018H	EYE FOUNDATION HOSPITAL	248,643
HOS0019H	HELEN KELLER MEMORIAL	5,123,285
HOS0021H	DALE MEDICAL CENTER	6,655,628
HOS0022H	CHEROKEE BAPTIST M.C.	294,786
HOS0023H	BAPTIST - MONTGOMERY	8,738,761
HOS0024H	JACKSON HOSPITAL & CLINIC	4,004,927
HOS0025H	GEORGE H. LANIER MEMORIAL	1,568,431
HOS0027H	ELBA GENERAL HOSPITAL	825,713
HOS0029H	EAST ALABAMA M.C.	22,353,389
HOS0031H	PHENIX MEDICAL PARK	1,469,186
HOS0032H	WEDOWEE HOSPITAL	597,892
HOS0033H	U.A.B. HOSPITALS	73,273,587
HOS0034H	COMMUNITY - TALLASSEE	656,121
HOS0035H	CULLMAN MEDICAL CENTER	6,184,463
HOS0036H	ANDALUSIA HOSPITAL	1,308,425
HOS0038H	STRINGFELLOW MEMORIAL HOSPITAL	400,307
HOS0039H	HUNTSVILLE HOSPITAL	29,602,810
HOS0040H	GADSDEN REGIONAL	3,604,697
HOS0043H	VAUGHAN CHILTON M.C.	117,936
HOS0044H	MARION BAPTIST M.C.	234,027
HOS0045H	FAYETTE COUNTY HOSPITAL	622,421
HOS0046H	RIVERVIEW REGIONAL MEDICAL CENTER	1,980,781
HOS0047H	GEORGIANA DOCTORS HOSPITAL	155,188
HOS0049H	MEDICAL CENTER ENTERPRISE	2,039,820
HOS0050H	BLOUNT MEMORIAL	450,599
HOS0051H	GREENE COUNTY	511,313
HOS0052H	LAKESHORE COMMUNITY HOSPITAL	292,782
HOS0053H	ATMORE COMMUNITY HOSPITAL	594,029
HOS0054H	PARKWAY MEDICAL CENTER	435,730
HOS0055H	FLOWERS HOSPITAL	1,755,044

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HOS0056H	ST VICENT'S HOSPITAL	3,066,286
HOS0058H	BIBB MEDICAL CENTER	1,377,532
HOS0059H	LAWRENCE BAPTIST M.C.	545,934
HOS0061H	JACKSON COUNTY HOSPITAL	4,328,312
HOS0062H	WIREGRASS HOSPITAL	2,159,593
HOS0064H	CARRAWAY METHODIST MEDICAL CENTER	7,223,790
HOS0065H	RUSSELL HOSPITAL	1,289,396
HOS0066H	FLORALA MEMORIAL HOSPITAL	63,152
HOS0068H	LLOYD NOLAND HOSPITAL	1,714,909
HOS0069H	LAKEVIEW COMMUNITY HOSPITAL	521,658
HOS0072H	COOSA VALLEY MEDICAL CENTER	2,531,928
HOS0073H	CLAY COUNTY HOSPITAL	2,060,600
HOS0078H	NORTHEAST ALABAMA R.M.C.	17,532,099
HOS0079H	ATHENS - LIMESTONE HOSPITAL	5,096,145
HOS0080H	LAMAR REGIONAL HOSPITAL	19,162
HOS0081H	MONTGOMERY REGIONAL	4,008,005
HOS0083H	SOUTH BALDWIN HOSPITAL	2,556,728
HOS0084H	HEALTHSOUTH MEDICAL CENTER	585,477
HOS0085H	DECATUR GENERAL HOSPITAL	10,928,708
HOS0086H	CARRAWAY NORTHWEST M.C.	399,146
HOS0087H	UNIVERSITY SOUTH ALABAMA M.C.	51,880,412
HOS0089H	WALKER BAPTIST M.C.	3,588,039
HOS0090H	PROVIDENCE HOSPITAL	1,851,759
HOS0091H	GROVE HILL MEMORIAL	824,702
HOS0092H	DCH REGIONAL MEDICAL CENTER	31,894,328
HOS0094H	NORTHWEST MEDICAL CENTER	787,522
HOS0095H	HALE COUNTY HOSPITAL	243,982
HOS0097H	ELMORE COMMUNITY HOSPITAL	2,125,262
HOS0098H	RANDOLPH COUNTY HOSPITAL	771,568
HOS0099H	D.W. McMILLAN MEMORIAL	1,124,136
HOS0100H	THOMAS HOSPITAL	1,916,327
HOS0101H	CITIZEN'S BAPTIST M.C.	2,986,471
HOS0102H	J. PAUL JONES HOSPITAL	646,098
HOS0103H	BIRMINGHAM BAPTIST PRINCETON	3,453,058
HOS0104H	BIRMINGHAM BAPTIST MONTCLAIR	3,856,918
HOS0108H	AUTAUGA MEDICAL CENTER	185,899
HOS0109H	PICKENS COUNTY HOSPITAL	1,089,397
HOS0110H	BULLOCK COUNTY HOSPITAL	880,250
HOS0112H	BRYAN W. WHITFIELD MEMORIAL	6,727,453
HOS0113H	MOBILE INFIRMARY MEDICAL CENTER	3,837,601
HOS0114H	BESSEMER CARRAWAY	1,915,008
HOS0115H	RED BAY HOSPITAL	342,429
HOS0117H	THE MEDICAL CENTER	-
HOS0118H	FOUR RIVERS MEDICAL CENTER	1,978,916
HOS0119H	USA DOCTORS HOSPITAL	17,406,320
HOS0120H	MONROE COUNTY HOSPITAL	3,269,540
HOS0121H	VAUGHAN REGIONAL M.C.	3,893,213

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METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

HOS0123H	FLORENCE HOSPITAL	297,885
HOS0124H	MEDICAL CENTER SHOALS	305,529
HOS0125H	BURDICK WEST MEMORIAL	581,216
HOS0126H	EDGE REGIONAL M.C.	1,619,368
HOS0127H	HUNTSVILLE HOSPITAL EAST	750,230
HOS0128H	VAUGHAN JACKSON M.C.	469,386
HOS0129H	NORTH BALDWIN HOSPITAL	2,235,013
HOS0130H	ST. CLAIR REGIONAL HOSPITAL	917,408
HOS0131H	CRESTWOOD HOSPITAL	269,894
HOS0134H	WASHINGTON COUNTY INFIRMARY	263,832
HOS0137H	COOPER GREEN HOSPITAL	74,518,403
HOS0138H	HILL HOSPITAL SUMTER COUNTY	317,173
HOS0139H	AMI BROOKWOOD MEDICAL CENTER	3,505,147
HOS0143H	WOODLAND COMMUNITY HOSPITAL	913,266
HOS0144H	SPRINGHILL MEMORIAL HOSPITAL	731,749
HOS0145H	NORTHPORT HOSPITAL - DCH	2,840,534
HOS0146H	JACKSONVILLE HOSPITAL	1,785,391
HOS0148H	VAUGHAN EVERGREEN M.C.	768,997
HOS0149H	EAST MONTGOMERY MEDICAL CENTER	1,942,119
HOS0150H	L.V. STABLER MEMORIAL	704,583
HOS0152H	USA KNOLLWOOD PARK HOSPITAL	5,043,193
HOS0155H	VAUGHAN PERRY HOSPITAL	192,478
HOS3025H	LAKESHORE HOSPITAL	129,972
HOS3300H	CHILDREN'S HOSPITAL	56,438,529

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Effective Date: 07/01/94

(h) Publicly owned acute care hospitals will be paid an enhanced payment not to exceed Medicare upper limits in the aggregate. The rate will be determined by the following methodology:

(1) Publicly owned acute care hospitals in urban groupings (as indicated in 4.19-A, II (l)(1)(a), page 3) will be paid an amount above any applicable ceilings up to their computed cost, multiplied by Medicaid paid days.

(2) All publicly owned acute care hospitals will be paid an amount determined by: the computed per diem cost multiplied by a percentage determined by the Alabama Medicaid Agency for Medicaid paid days (including Health Maintenance Organization (HMO) and Maternity Waiver days).

(3) All public hospitals will receive an enhanced payment consisting of two tiers for public urban hospitals and one tier for public rural hospitals. The first tier will be to reinstate amounts lost due to the low occupancy adjustment (LOA) and the class ceilings, both administrative and general (A & G) and overall.

EXAMPLE OF FIRST TIER

Hospital A had an LOA of $50 per day, A & G of $100 per day with a class ceiling of $95 per day, an overall per diem rate of $700 per day with a class ceiling of $650 per day. Their enhanced payment would be:

LOA	$50
A & G ceiling difference ($100 - $95)	$5
Overall ceiling difference ($700 - $650)	$50
Total Enhancement	$105

Hospital B had an LOA of $40 per day, A & G of $90 per day with a class ceiling of $95 per day, an overall per diem rate of $652 per day with a class ceiling of $650 per day. Their enhanced payment would be:

LOA	$40
A & G ceiling difference ($90 - $95)	$0
Overall ceiling difference ($652 - $650)	$2
Total Enhancement	$42

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SECOND TIER

The second tier will be an amount added to each public hospital's per diem rate. This amount will represent a portion of a pool calculated using the Medicare upper payment limit theory, less amounts reimbursed to the public urban hospitals under the first tier explained above.

The total pool will be calculated using the public hospital's total inpatient revenue, less any SNF and non-covered revenues, divided by total revenues, to determine percentage A.

Percentage A will then be multiplied by total expenses, less any SNF and non-covered expenses, to arrive at allowable inpatient costs (AIC).

AIC will then be divided by total adult and boarder inpatient days (days incurred by newborn when mother has been discharged) to determine Medicare costs per day (MCPD).

MCPD will then be multiplied by paid Medicaid days to determine what Medicaid would have paid using Medicare principles.

Paid Medicaid days will then be multiplied by the Medicaid per diem rate (effective July 1 of the current rate year) to determine what Medicaid paid. The aggregate payments using Medicare principles would then be compared to the amount Medicaid paid to determine the upper limit.

The amount determined to be paid under the first tier will then be subtracted from this Medicare upper limit pool. The remainder will be divided by the total estimated Medicaid payments to arrive at the percentage add-on each public hospital would receive.

The Maternity and HMO days are not included in the calculation of the upper payment limit pool. Maternity and HMO days will be included in the enhanced payment calculation, since they are paid Medicaid days and the rates increase when the per diem rates are increased.

Effective Date: 01/01/95

(i) Acute care hospitals in the unique or specialized hospital group (as defined under paragraph II(l)(3) on page 3 of this State Plan) whose inpatients are predominantly under 18 years of age will be paid an enhanced payment. The rate will be the Medicaid computed per diem rate multiplied by thirty percent for all paid Medicaid days.

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III. PER DIEM RATE COMPUTATION (continued)

Effective Date: 10/01/2024

(j) For the period October 1, 2017, through September 30, 2025, each hospital shall receive an inpatient Medicaid base (per diem) payment, in accordance with the following:

(1) Medicaid shall pay each hospital as a base (per diem) amount for state fiscal year 2025 the greater of the hospitals current per-diem as published for fiscal year 2022 or 68% of total inpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2019, divided by the total paid inpatient hospital days incurred by that hospital in state fiscal year 2019, multiplied by the inpatient hospital days incurred by each hospital during fiscal year 2025.

Effective October 1, 2018, Long Acting Reversible Contraceptives (LARCs) will be reimbursed separately from the inpatient daily per diem rate when the LARC is provided as part of the inpatient obstetrical delivery or in the outpatient setting immediately after discharge. A separate outpatient claim may be submitted by the hospital for reimbursement under the appropriate HCPCS code when the LARC is provided in the inpatient setting immediately after delivery.

(2) Base (per diem) payments for state fiscal year 2025 will not be made to any non state government owned or operated Hospital owned, state owned or operated or privately owned or operated hospital that was in operation during the hospital's fiscal year ending in 2009 that ceases to operate as a hospital, beginning on the date that the facility ceases to operate as a hospital.

(3) Quarterly access payments as outlined in paragraph (k) and (l) on pages 6I through 6J will be distributed as follows:

a. State owned and operated hospitals' inpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap, reallocate any access to ensure the state owned mental health facility does not exceed OBRA payments, reallocate $25,773,196 and $55,228,277 to be paid to rural and children hospitals, respectively, in proportion to all rural and children hospitals total upper payment limit and finally reduce any access payments to ensure a payment over billed amount is not made. 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' inpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap then reduce any access payments to ensure a payment over billed amount is not made and reallocate $25,773,196 and $55,228,277 to be paid to rural and children hospitals, respectively, in proportion to all rural and children hospitals total upper payment limit. All remaining access will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.

c. Privately owned and operated hospitals' inpatient access payments will be distributed first by paying free standing psychiatric hospitals per paragraph (n) on page 6J, then removing any negative Upper Payment Limit Gap, reallocating $25,773,196 and $55,228,277 to be paid to rural and children hospitals, respectively, in proportion to all rural and children hospitals total upper payment limit, and finally reduce any access payments to ensure a payment over billed amount is not made. All remaining access payments will be allocated based on the hospitals Medicaid days in relation to the total Medicaid days.

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III. PER DIEM RATE COMPUTATION (continued)

(k) For the period October 1, 2024, through September 30, 2025, the amount available for inpatient hospital access payments for state owned or operated hospitals, Non state government owned or operated hospitals', and Privately owned and operated hospitals' that have Medicare payments identified in the CMS Form 2552-10 cost report ended in the rate year one year prior to the beginning of the rate year shall be calculated as follows:

(1) A Medicare per-diem shall be calculated using the CMS Form 2552-10 cost report ended in the rate year one year prior to the beginning of the rate year.

(a) Medicare Payments are obtained from the following cost report lines:

1. Acute Care Hospitals: Sum of Worksheet E Part A column 1 line 59, Worksheet E-3 Part II column 1 line 12, and Worksheet E-3 Part III column 1 line 13.
2. Critical Access Hospitals: Sum of Worksheet E-3 Part V column 1 line 19 and Worksheet E-3 Part III column 1 line 19.
3. Children's Hospitals: Worksheet E-3 Part I column 1 line 4.
4. Psychiatric Hospitals: Worksheet E-3 Part II column 1 line 12.

(b) Medicare days are obtained from the following cost report Lines:

1. Acute Care Hospitals: Sum of Worksheet S-3 Part I column 6 lines 14, 16, and 17.
2. Critical Access Hospitals: sum of Worksheet S-3 Part I column 6 lines 14, 16, and 17.
3. Children's Hospitals: sum of Worksheet S-3 Part I column 6 lines 14, 16, and 17
4. Psychiatric Hospitals: sum of Worksheet S-3 Part I column 6 lines 14, 16, and 17.

(2) The Medicare per-diem calculated in the previous step will be multiplied by the Medicaid hospital days obtained from the State's MMIS system for each hospital's discharges during the applicable cost report ended in the rate year one year prior to the beginning of the rate year for claims which would be covered during SFY 2025 to determine the amount Medicare would have paid for Medicaid services. Medicaid utilization impacted by the COVID-19 public health emergency will be adjusted to reflect estimated utilization levels in the rate year prior to the COVID-19 public health emergency.

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(3) The amount Medicare would have paid for Medicaid services will be multiplied by an increase in cost due to the CMS Market Basket Inpatient Hospital PPS (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData) and a separate utilization increase based on change in paid days a linear regression completed for the previous five State Fiscal Years, excluding State Fiscal Years 2020, 2021, and 2022, 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.

(4) The amount determined in this step will be the Upper Payment Limit amount set forth in 42 CFR 447.272. An aggregate Upper Payment Limit amount will be established for State owned and operated hospitals, Non state government owned or operated hospitals, and Privately owned and operated hospitals'.

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III. PER DIEM RATE COMPUTATION (continued)

(5) The Medicaid allowed amount, for claims included in paragraph (2), was obtained from the MMIS for the same period as outlined in paragraph (1) and includes the utilization adjustment described in paragraph (2). The utilization increase identified in paragraph (3) and the cost report factors in paragraph (3) was applied to the Medicaid allowed amount to standardize all hospital payments to the mid-point of the State Fiscal Year the cost reporting year ends during.

(6) The difference between Medicare Payments for Medicaid Services determined in paragraph (4) and the Medicaid payments in paragraph (5) will be the Upper Payment Limit Gap amount for State owned and operated hospitals, Non state government owned or operated hospitals', and Privately owned and operated hospitals'. The Upper Payment Limit Gap will represent the maximum amount the State shall pay for Access payments to State owned and operated hospitals.

(l) For the period October 1, 2024, through September 30, 2025, the amount available for inpatient hospital access payments for privately owned and operated hospitals and non-state government owned and operated hospitals that do not have sufficient Medicare data to calculate a Medicare per-diem UPL calculation determined from paragraph (4) shall be calculated as follows:

(1) Data from hospital's CMS Form 2552-10 cost reports that ended in the rate year one year prior to the beginning of the rate year (ex. Cost reports ending in rate year 2017 for the rate year beginning October 1, 2018) will be used to determine the upper payment limit.

(2) A routine inpatient cost to charge ratio and an inpatient ancillary cost to charge ratio are determined from each cost report by obtaining the following information from the CMS Form 2552-10 cost reports for each hospital:

(a.) Inpatient routine cost to charge ratio

(i.) Total cost will be accumulated from Worksheet B Part I Column 24 for Lines 30-43.

(ii.) Total charges will be accumulated from Worksheet C Part I Column 6 for CMS Lines 30-43.

(iii.) Total cost per paragraph (i) will be divided by total charges per paragraph (ii) to determine the inpatient routine cost to charge ratio for each hospital.

(b.) Inpatient ancillary cost to charge ratio

(i.) Total cost for each of the following centers on Worksheet B Part I is obtained: CMS Lines 50-76.99 and 90-93.99.

(ii.) Inpatient charges for each of the following cost centers on Worksheet C Part I Column 6 are obtained: CMS Lines 50-76.99 and 90-93.99.

(iii.) 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.

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III. PER DIEM RATE COMPUTATION (continued)

(iv.) Inpatient charges for each CMS Line in paragraph (ii) will be divided by the total charges for each CMS Line in paragraph (iii) to determine an inpatient percentage of charges.

(v.) The total cost for each CMS Line in paragraph (i) will be multiplied by the inpatient percentage of charges for each CMS Line in paragraph (iv) to determine the inpatient cost.

(vi.) Total inpatient cost determined in paragraph (v) will be divided by total inpatient charges from paragraph (ii) to determine an inpatient ancillary cost to charge ratio.

(c.) For privately owned and operated psych hospitals that do not file a Medicare cost report, the Medicaid submitted cost report will be used as follows:

(i.) Total inpatient cost Per Medicaid Worksheet C Column 2 Line 150 and Line 156 through Line 196.

(ii.) Total inpatient charges Per Medicaid Worksheet C Column 1 Line 150 and Line 156 through Line 196.

(iii.) Total inpatient cost to charge ratio will be paragraph (i) divided by paragraph (ii).

(3) Inpatient charges will be obtained from the State's MMIS system for each hospital's discharges during the applicable cost report ended in the rate year one year prior to the beginning of the rate year for claims which would be covered during SFY 2025. The inpatient charges will be obtained at the revenue code level. Medicaid utilization impacted by the COVID-19 public health emergency will be adjusted to reflect estimated utilization levels in the rate year prior to the COVID-19 public health emergency.

(4) Inpatient charges for each hospital with revenue codes 001 through 219 will be multiplied by the inpatient routine cost to charge ratio determined in paragraph (2)(a)(iii) for each hospital to determine the inpatient routine cost.

(i.) For privately owned and operated psych hospitals that do not file a Medicare cost report, the MMIS inpatient charges will be multiplied by the cost to charge ratio in paragraph (c) to determine inpatient cost for privately owned and operated psych hospitals.

(5) Inpatient charges for each hospital with revenue codes 220 through 999 will be multiplied by the inpatient ancillary cost to charge ratio determined in paragraph (2)(b)(vi) for each hospital to determine the inpatient ancillary cost.

(6) Total inpatient Medicaid cost will be the total of paragraph (4) and (5). The total inpatient Medicaid cost will have the following amounts added:

(a.) The Medicaid cost will be increased by the Medicaid inpatient percentage of CRNA cost removed on Worksheet A-8 for each hospital. The Medicaid inpatient percentage is determined by dividing total Medicaid inpatient charges by total charges for the hospital.

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(7) 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 five State Fiscal Years, excluding State Fiscal Years 2020,2021, and 2022, 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.

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(8) The Medicaid cost will be increased by the Medicaid inpatient percentage of the provider assessment paid by each hospital for the State Fiscal Year being calculated. The Medicaid inpatient percentage is determined by dividing total Medicaid inpatient charges from the cost report identified in paragraph (1) by total charges for the hospital from the cost report identified in paragraph (1).

The cost calculated in this paragraph will be the Upper Payment Limit amount set forth in 42 CFR 447.272 for privately owned and operated hospitals. An aggregate Upper Payment Limit amount will be established for each of the following hospital types: Privately owned and operated hospitals and Non-state governmental owned and operated hospitals.

(9) The Medicaid allowed amount for claims included in paragraph (3) was obtained from the MMIS and includes the utilization adjustment described in paragraph (3) 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 (7) and the cost report factors in paragraph (7) was applied to the Medicaid allowed amount to standardize all hospital payments to the mid-point of the State Fiscal Year including the ending date of the cost reporting year. The standardized Medicaid payments for State Fiscal Year ending in the cost reporting year were multiplied by the utilization increase amount and adjustment factor in paragraph (8) to determine the Medicaid payments for the rate year and the preceding rate year.

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III. PER DIEM RATE COMPUTATION (continued)

(10) The difference between Medicare cost for Medicaid Services determined in paragraph (8) on page 6I.5 and the Medicaid payments in paragraph (9) on page 6I.5 for the rate year will be the Upper Payment Limit Gap that will be used as the limit to the amount of Access payments outlined in paragraph (m) and (n) below.

(m) For the period October 1, 2024, through September 30, 2025, in addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible hospital, excluding free-standing psychiatric hospitals, shall receive inpatient hospital access payments each fiscal year. Inpatient hospital access payments shall include the following:

(1) An inpatient access payment to hospitals determined on a quarterly basis by the Alabama Medicaid Agency that complies with paragraph (3) below. Aggregate hospital access payments for each category of hospitals will be the amount calculated in paragraph (k)(7) for state owned or operated hospitals and the amount calculated in paragraph (l)(10) for non state government owned and operated hospitals and private hospitals. Annual amount to be paid for each State Fiscal Year will be made as indicated in paragraph (3) on page 6H.
(2) These additional inpatient hospital access payments shall be made on a quarterly basis.
(3) The inpatient hospital access payments shall not exceed the annual applicable hospital inpatient upper payment limit Gap for each category of hospitals submitted to CMS.

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III. PER DIEM RATE COMPUTATION (continued)

(n) For the period October 1, 2024, through September 30, 2025, in addition to any other funds paid to private free-standing psychiatric hospitals for inpatient hospital services to Medicaid patients, qualifying hospitals shall receive a private free-standing psychiatric hospital access payment equal to $300 per Medicaid inpatient day paid based on the Medicaid days per the cost report ending during the State Fiscal Year 2023.

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Effective Date: 10/01/93

IV. PROVIDERS WHICH SERVE A DISPROPORTIONATE NUMBER OF LOW INCOME PATIENTS

Certain payment adjustment shall be provided for hospitals which are determined to be adversely affected because they serve a disproportionate number of low income patients.

(a) In order to be eligible for this payment adjustment, a hospital shall meet the following criteria:

(1) The hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate of all in-state hospital providers participating in the Alabama Medicaid Program; or

(2) The hospital's low-income inpatient utilization rate exceeds 25 percent; or

(3) Be an acute care teaching hospital operated by a university of the State of Alabama; or

Effective Date: 10/01/94

(4) Be an acute care publicly owned hospital; or

Effective Date: 10/01/95

(5) Be an acute care hospital that is a member of a prepaid health plan; or

Effective Date: 01/01/95

(6) Acute care hospitals in a county, with a population greater than 200,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds the state wide Medicaid utilization average; or

(7) Acute care hospitals in a county, with a population not less than 75,000 and not greater than 100,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds one-half of the state wide Medicaid utilization average; and

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Effective Date: 10/01/93

(8) Effective for services rendered on or after July 1, 1988, the hospital must have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetric services to individuals entitled to such services under the Alabama Medicaid Program. (In the case of a hospital located in an area designated by Medicaid as rural, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.) Hospitals that did not offer routine obstetrical services to the general public as of December 21, 1987, or whose inpatients are predominantly individuals under 18 years of age are exempt from this requirement. Should a hospital begin offering non-emergency OB services on or after December 21, 1987, the requirement to have two obstetricians applies; and

Effective Date: 10/01/94

(9) Have a Medicaid inpatient utilization rate of not less than one percent.

Effective Date: 10/01/93

(b) If the applicable criteria in (a) above are met, then the payment adjustment shall be determined as follows:

(1) A factor of one quarter of one percent for every percentage point the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate (with a minimum of one quarter of one percent), or for every percentage point the hospital's Low-Income Utilization Rate exceeds twenty-five percent shall be computed.

(2) The applicable factor from (b)(1) above shall be applied to the hospital's allowable calculated per diem rate (excluding any education cost flow-through). The hospital shall be reimbursed its factored per diem rate plus any applicable education cost flow-through.

(3) In the instance of a hospital meeting two or more of the applicable criteria contained within section (a), two or more factored per diems shall be calculated, using the
Medicaid Inpatient Utilization factor and the Low-Income Utilization factor as in (b)(1) above. The hospital shall be reimbursed at the lower of the two factored per diems plus any applicable education cost flow-through.

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Disproportionate share payments to any public hospital shall not exceed uncompensated cost of care as defined in OBRA 93.

(c) As an alternative payment method, based upon availability of funds to be appropriated, hospitals that meet the applicable criteria in Section IV(a) above and which do not have their disproportionate share payment included in a capitation payment rate shall be compensated as follows:

(1) Disproportionate share hospitals shall be grouped into eight groups as follows:

Group 1: Acute care hospitals whose inpatients are predominantly under 18 years of age.

Group 2: Acute care publicly owned hospitals.

Group 3: Acute care hospitals located in a rural area and acute care hospitals licensed for one-hundred (100) beds or less and located in a metropolitan statistical area (MSA).

Effective Date: 10/01/95

Group 4: Psychiatric hospitals owned and operated by the State of Alabama.

Group 5: Psychiatric hospitals, other than those owned and operated by the State of Alabama, which provide services to individuals under 21 years of age.

Effective Date: 01/01/95

Group 6: Acute care hospitals in a county, with a population greater than 200,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds the statewide Medicaid utilization average.

Group 7: Acute care hospitals in a county, with a population not less than 75,000 and not greater than 100,000 (according to the latest U.S. census), without a publicly owned hospital, whose Medicaid utilization exceeds one-half of the state wide Medicaid utilization average.

Effective Date: 10/01/95

Group 8: Hospitals which are members of a prepaid health plan.

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Effective Date 10/01/94

(2) Annually, the Alabama Medicaid Agency shall determine a sum of funds to be appropriated to each group of hospitals, in lieu of the payment methodology contained in Section IV(b). Disproportionate share payments to any public hospital shall not exceed uncompensated cost of care as defined in OBRA 93. Subject to this limitation, calculation of the payments shall be as follows:

(A) Group 1

$$\frac{\text{Uncompensated Cost}}{\text{Total Uncompensated Cost for Hospitals in Group One}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

(B) Group 2

$$\frac{\text{Uncompensated Cost}}{\text{Total Uncompensated Cost for Hospitals in Group Two}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

(C) Group 3

$$\frac{\text{Medicaid Inpatient Days}}{\text{Total Medicaid Inpatient Days for Hospitals in Group Three}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

(D) Group 4

$$\frac{\text{Medicaid Inpatient Days}}{\text{Total Medicaid Inpatient Days for Hospitals in Group Four}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

(E) Group 5

$$\frac{\text{Medicaid Inpatient Days}}{\text{Total Medicaid Inpatient Days for Hospitals in Group Five}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

Effective Date 01/01/95

(F) Group 6

$$\frac{\text{Hospital}}{\text{Total hospitals in Group Six}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

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(G) Group 7

Hospital	X	Appropriated Funds	= Disproportionate Share Payment
Total hospitals in Group Seven			

(H) Group 8

Uncompensated care	X	Appropriated Funds	= Disproportionate Share Payment
Total Uncompensated care in Group Eight			

Note: Aggregate appropriated funds will not exceed the disproportionate share hospital payments limits in 42 CFR §447.296 through §447.299.

If a hospital meets the criteria in IV(a) and does not fall into one of the payment groupings in IV(c), they would be paid using section IV(b).

Effective Date: 10/01/93

(3) In the event funds are not available to be appropriated for distribution under this methodology, these hospitals shall be reimbursed in accordance with the methodology contained in Section IV (b).

(d) The payment shall be an amount that is reasonable related to costs, volume, or proportion of services provided to patients eligible for medical assistance under the State Plan and to low income patients.

(e) Alabama shall pay these hospitals at least the minimum payment adjustment as specified in Section IV(b) of the State Plan and no more than that determined to be available in IV(c)(2) of this section.

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IV. PROVIDERS WHICH SERVE A DISPROPORTIONATE NUMBER OF LOW INCOME PATIENTS (Cont.)

Effective Date: 10/01/2024

(f) For the period from October 1, 2021, to September 30, 2025, the Alabama Medicaid Agency shall appropriate and expend the full disproportionate share allotment to hospitals under Section 1923(f) (3) of the Social Security Act (the Act) in a manner consistent with the hospital-specific DSH limits under section 1923(g) of the Act.

(1) Payments to disproportionate share hospitals shall be made to all hospitals qualifying for disproportionate hospital payments under Section 1923(d) and 1923(b) of the Social Security Act.

(2) Medicaid shall pay qualifying non-state government and state owned disproportionate share hospitals an amount up to each hospital's allowable uncompensated care cost under the hospital specific DSH limit in Section 1923(g) of the Social Security Act as outlined in Exhibit C. State owned institutions for mental disease shall receive no more than the IMD allotment.

(3) Qualifying non-state government and state owned disproportionate share hospitals as defined on Attachment 4.19-A Page 3A shall receive an amount such that the sum of inpatient hospital payments, outpatient payments, and disproportionate share hospital cost do not exceed each hospital's DSH limit under 1923(g) of the Social Security Act. Medicaid cost for these services shall be allowable cost determined in accordance with the Medicare Principles of Reimbursement, the applicable CMS 2552 and the DSH final rule effective January 19, 2009 which states on page 77913 "(t)he treatment of inpatient and outpatient services provided to the uninsured and the underinsured…must be consistent with the definition of inpatient and/or outpatient services under the approved Medicaid State Plan."

(4) Eligible hospitals administered by the Department of Mental Health shall be paid an amount of DSH funds not to exceed the DSH IMD Allotment published annually by CMS.

(5) The disproportionate share hospital allotment remaining after disproportionate share hospital payments have been made to non-state government and state owned hospitals shall be paid to private hospitals, as defined on Attachment 4.19-A Page 3A, using their available cost in relation to total private cost. Disproportionate share hospital payments shall be paid to eligible private hospitals who do not exceed their estimated disproportionate share hospital payment limit calculated at the beginning of the State Fiscal Year.

(6) An initial disproportionate share hospital payment to each hospital shall be made during the first month of the state fiscal year. Additional disproportionate share hospital payments may be made during the fiscal year based on analysis of payments during the fiscal year and changes in Federal allocations. Payments to privately owned and operated hospitals will be made as indicated in paragraph (5) on page 8D.

(7) As required by Section 1923(j) of the Social Security Act related to auditing and reporting of DSH hospital payments, Alabama Medicaid will implement procedures to comply with DSH Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Beginning with the audit of the Medicaid State Plan Rate Year ended September 30, 2011, the definition of individuals who have no health insurance (or other source of third party coverage) will be based on the definition published in the December 3, 2014, Federal Register, with an effective date of December 31, 2014.

The Medicaid Agency will recoup funds from any hospital that exceeded its hospital specific DSH limit as a result of audits or other corrections and shall redistribute to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit in the following manner:

(a) The amount of the DSH payment made to the hospital will be recouped by the Alabama Medicaid Agency to the extent necessary to reduce the DSH payment to an allowable amount.

(b) Amounts recouped from privately owned and operated hospitals with payments in excess of the audited hospital specific DSH limits, will be placed into a redistribution pool. Redistribution will be made to remaining privately owned and operated hospitals that do not exceed their hospital specific DSH limit. The allocation will be made based on these remaining hospitals available uncompensated care. No privately owned and operated hospital shall exceed its hospital specific DSH limit after redistribution. If any private DSH payments cannot be redistributed within this ownership group, the remaining DSH payments after redistribution to privately owned and operated hospitals will be placed in the redistribution pool described in paragraph (7)(c) on page 8E for qualifying non-state government and state owned disproportionate share hospitals. If any privately owned and operated DSH payments remain after being placed in the redistribution pool described in paragraph (7)(c) on page 8E, the Federal Share of the DSH payments that remain will be returned to the Federal Government.

(c) Amounts recouped from qualifying non-state government and state owned disproportionate share hospitals with payments in excess of the audited hospital specific DSH limits, along with any remaining DSH payments from paragraph (7)(b) on page 8E will be placed into a redistribution pool. Redistribution will be made to remaining qualifying non-state government and state owned disproportionate share hospitals that do not exceed their hospital specific DSH limit. The allocation will be made based on these remaining hospitals available uncompensated care. No qualifying non-state government and state owned disproportionate share hospital shall exceed its hospital specific DSH limit after redistribution. If any qualifying non-state government and state owned DSH payments cannot be redistributed within this ownership group, the remaining DSH payments after redistribution to qualifying non-state government and state owned hospitals will be placed in the redistribution pool described in paragraph (7)(b) on page 8E. If any qualifying non-state government and state owned DSH payments remain after being placed in the redistribution pool described in paragraph (7)(b) on page 8E, the Federal Share of the DSH payments that remain will be returned to the Federal Government.

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V. RATE OF RETURN ON EQUITY CAPITAL

The rate of return on average equity capital is a percentage equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program. The rate of return varies as the interest rates on such issues of public debt obligations vary.

VI. APPROVED CAPITAL EXPENDITURE PROJECTS

(a) Regardless of any other provision in this state plan, the Alabama Medicaid Agency will not recognize any capital project construction costs arising from bed additions, renovation, or any other construction resulting from a Certificate of Need (CON) dated on or after October 1, 1983. (Replacement of equipment is not affected by this limitation.)

(b) For those hospitals with approved capital expenditure projects resulting from a CON dated prior to October 1, 1983, the following procedures and/or any other procedures deemed necessary by the Agency will be performed to reimburse the approved CON projects of those hospitals which qualify under the above listed circumstances:

(1) The hospital will submit a budgeted cost report containing estimated total Medicaid cost.

(2) The Agency will compute a budgeted per diem rate subject to the current ceiling. This rate must exceed the hospital's current rate by 10% (if the current rate is not

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limited by the overall ceiling) in order to be considered for a rate, increase.

(3) The total budgeted rate is subject to retroactive adjustment after comparison to the rate calculated from the applicable cost report containing actual allowable costs.

VII. RECORDS

(a) All hospitals must keep financial and statistical records which document and justify costs. Only those costs which can be fully and properly substantiated will be allowed by Medicaid. All records must be available upon request to representatives, employees, or contractors of the Alabama Medicaid Agency, Alabama Department of Examiners of Public Accounts, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS).

(b) The records of related organizations must be available upon demand to those individuals or organizations as listed in Section VII.(a) of this plan.

Effective Date: 07/01/88

(c) The Alabama Medicaid Agency shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 447.203(a) and 42 CFR 433.32. If an audit by or on behalf of the state or federal government has begun, but is not completed at the end of the three year period, or if audit findings have not been resolved at the end of the three year period, the reports shall be retained until resolution of the audit findings.

Effective Date: 06/01/90

VIII. **COST REPORT PENALTIES**

(a) Failure to File a Cost Report

1. Each Alabama hospital participating in the Alabama Medicaid program shall submit a cost report in the manner prescribed by the Alabama Medicaid Agency. If a complete uniform cost report is not filed by the due date (90 days after the Medicaid elected FYE), the hospital shall be charged a penalty of one hundred dollars ($100.00) per day for each calendar day after the due date. This penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting

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documentation. A cost report that is over ninety (90) days late may result in termination of the hospital from the Medicaid program.

2. Further, the entire amount paid to the hospital during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The hospital will have thirty (30) days to refund the overpayments or submit the cost report after which Medicaid may institute a suit or other action to collect this overpayment amount. No further payment will be made to the hospital until the cost report has been received by Medicaid.

(b) Reporting Negligence

1. Whenever a provider includes a previously disallowed cost on a subsequent years' cost report, if the cost included is attributable to the same type good or service under substantially the same circumstances as resulted in the previous disallowance, a negligence penalty of up to $10,000 may be assessed at the discretion of the Alabama Medicaid Agency.

2. The penalty imposed under item (b)(1) above shall be in addition, and shall in no way affect Medicaid's right to also recover the entire amount of any overpayment caused by the provider's, or its representative's negligence.

3. A previously disallowed cost, for the purposes of a negligence penalty assessment, is a cost previously disallowed as the result of a desk review or a field audit of the provider's cost report by Medicaid and such cost has not been reinstated by a voluntary action of Medicaid. The inclusion of such cost on a subsequent cost report by the provider, or its representative, unless the provider is pursuing an administrative or judicial review of such disallowance, will be considered as negligent and subject to the penalty imposed by this rule.

IX. AUDIT

To insure that payment of inpatient hospital costs is being made on a reasonable basis, comprehensive hospital desk review and audit programs have been developed (42 CFR 447.202). Using these programs, Medicaid shall perform the following:

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(a) Desk review the cost reports as filed and include only the appropriately determined allowable cost in the prospective per diem rate calculations.

(b) Determine the necessity, scope, and format for on-site audits.

(c) Perform on-site audits when indicated in accordance with Title XIX Principles of Reimbursement.

(d) Recalculate, when appropriate, the prospectively determined per diem rate giving effect to audit adjustments.

X. PAYMENT ASSURANCE

The Medicaid Agency will pay each hospital which furnishes allowable services, in accordance with the requirements of the State Plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the Alabama Title XIX Inpatient Hospital Reimbursement Plan.

XI. PROVIDER PARTICIPATION

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of hospitals in the program so that eligible persons can receive the medical care and services included in the State Plan at least to the extent available to the general public.

XII. PAYMENT IN FULL

Participation in the program shall be limited to hospitals who accept, as payment in full, the amount paid in accordance with the State Plan.

XIII. UPPER LIMITS

In no instance will the Medicaid per diem rate exceed, in the aggregate, the amount which would be paid by Medicare for comparable inpatient services.

XIV. APPEALS

(1) Except as herein prohibited, any provider of hospital services under the Medicaid program may appeal any action resulting from the provisions of the State Plan in accordance with the

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normal appeals procedures of the Alabama Medicaid Program. The following items will not be subject to appeals under these procedures:

(a) The use of Medicaid standards and principles of reimbursement.

(b) The method of determining the trend factor.

(c) The use of all-inclusive prospective reimbursement rates.

(d) The use of hospital group ceilings.

(2) A hospital may, on the basis of appeal, be granted an exception for one rate period only. Any further exceptions must be appealed individually. As a condition of appeal, the Alabama Medicaid Agency may require the hospital to submit to a comprehensive operational review. Such review will be made at the discretion of the Alabama Medicaid Agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

XV. CO-PAY

Effective Date: 09/01/86

Per diem payments are subject to co-pay; the amount of co-pay per admission is listed in Section 4.18-A of the State Plan.

XVI. PAYMENT FOR SERVICES RENDERED AT AN INAPPROPRIATE LEVEL OF CARE

Effective Date: 08/01/94

(1) Reimbursement will be made for medically necessary services rendered at an inappropriate level of care (lower than acute). Medical necessity will be determined for eligible individuals by applying the following:

(a) Medical need criteria for services routinely provided by a nursing facility;

(b) Verification of no less than a three-day stay (consecutive) for acute care services; and

(c) Verification of the non-availability of a nursing facility bed.

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(2) Reimbursement will be made on a per diem basis at the statewide nursing facility average rate per paid day for routine services furnished during the previous calendar year.

(3) Initial certification will not exceed thirty (30) days. If the patient is not placed in a nursing facility at the end of the initial thirty (30) day period, recertification may be made every additional thirty (30) days based on prior authorization by Medicaid.

XVII. THIRD PARTY PAYMENTS

In the event a Medicaid patient has insurance coverage for inpatient services provided by a hospital, the hospital is required to file for the patient's insurance before a claim for Medicaid payment may be filed. The Medicaid claim must indicate the amount of third party payment received or attach a copy of a rejection notice. Reimbursement to a hospital for inpatient services to eligible Medicaid patients will be made only after such reimbursement has been reduced by all third party payments.

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Effective Date: 10/01/11

XVIII. OUT-OF-STATE HOSPITAL INPATIENT RATES

Payment for inpatient services provided by all out-of-state hospitals shall be the lesser of the submitted covered charges or the Alabama flat rate which shall be composed of the average of the per diem rates paid to out-of-state hospitals in FY 2009 inflated annually by the Global Insight.

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XX. MISCELLANEOUS

(a) The Alabama Medicaid Agency will utilize appropriate methods of notifying the public concerning proposed substantial changes in methods and/or standards, and prior to the implementation of any substantial change in methods and/or standards, the public will have an opportunity to review and comment on the proposed changes.

(b) Detailed information regarding the reimbursement methodology and related matters appears in Chapter 23 of the Alabama Medicaid Agency Administrative Code.

EXHIBIT A

LOW OCCUPANCY ADJUSTMENT FOR URBAN HOSPITALS

$$LOA = \left(1 - \frac{TBD}{YABD}\right) ACC$$

TBD = Total Bed Days Actually Used During the Cost Report Period Exclusive of Nursery Bassinets and/or Separately Certified non-Covered Units (i.e. Psych.).

ABD = Available Bed Days Which is Determined by Multiplying the Total Licensed Beds Times the Number of Days in the Cost Report Period Exclusive of Nursery Bassinets and/or Separately Certified non covered Units (i.e. psych.)

ACC = Allowable Capital Costs

Y = Occupancy Factor

(Y = 70% 100 beds or less)
(Y = 80% 101 beds or less)

EXHIBIT B
Page 1

NATIONAL MARKET BASKET PRICE PROXIES
HOSPITAL INPATIENT OPERATING COSTS

EXPENSE CATEGORY	RELATIVE WEIGHT*	HCFA-DESIGNATED PRICE VARIABLE
Wages & Salaries	57.24	Average Hourly Earnings, Hospital Workers (SIC 806)
Employee Benefits	8.22	Supplements to Wages and Salaries per Employee in Nonagricultural Establishments
Professional Fees, Medical	--	Consumer Price Index, All Urban Physicians' Services
Professional Fees, Other	0.59	Index of Hourly Earnings of Production Workers, Private Nonfarm
Malpractice Insurance Premiums	1.96	Hospital Malpractice Insurance Premiums
Food	3.56	a. Consumer Price Index, All Urban, Food and Beverages b. Producer Price Index, Processed Food and Feeds
Fuel & Other Utilities	2.76	a. Implicit Price Deflator, Consumption of Fuel Oil and Coal b. Implicit Price Deflator Consumption of Electricity c. Implicit Price Deflator Consumption of Natural Gas d. Consumer Price Index, All Urban, Water and Sewerage Maintenance
Drugs	2.82	Producer Price Index, Preparations, Ethical (Prescription)

Chemicals and Cleaning Products	2.15	Producer Price Index, Chemicals and Allied Products
Surgical and Medical Instruments and Supplies	2.03	Producer Price Index, Special Industry Machinery and Equipment
Rubber and Miscellaneous Plastics	1.84	Producer Price Index, Rubber and Plastic Products
Business Travel & Motor Freight	1.72	Producer Price Index, Textile Products and Apparel
Apparel and Textiles	1.65	Consumer Price Index, Textile Products and Apparel
Business Services	4.70	Consumer Price Index, All Urban, Services
All Other Miscellaneous	8.76	Consumer Price Index, All Urban, All Items
	100.0	

*HCFA input price index excludes capital, medical education, and medical professional fees. Weights are based on HCFA special studies.

The above relative weights are per Data Resources, Inc. (Health Care Costs) Volume V, Number 7, 3rd Quarter 1985 Series.

EXHIBIT B
Page 3

The National Hospital Input Price Index methodology will be utilized to isolate the effects of prices of goods and services for Alabama hospitals. Such an index will measure the average percent change in prices for a fixed "market basket" of hospital categories of expenses as forecasted by Data Resources, Inc. (Data Resources, Inc., Cost Forecasting Service, Regional Forecasting Models for Selected Components of the Hospital and Nursing Home Cost Index, 1750 K Street, Washington, DC 20006). Such a forecast combined with the historical period data, will provide a price index for hospital inpatient reimbursement in the state.

The National Hospital Input Price Index was developed utilizing a fixed set of weights for each of seven (7) categories of expenses. The article by Freeland, et al., in the HCFA Review (Summer 1979) discussed the various "market basket" comparisons, input-output data, and other survey designs which were utilized in the establishment of the Price Index. These were further refined by Data Resources, Inc., to provide a total of fourteen (14) basic Expense Categories. Relative cost weights were established from 1977 data to establish the final National Market Basket Price Proxies published in Health Care Costs (Data Resources, Inc., Vol. 1, No. 1, May 1981). This publication will provide market basket forecasts for a total of sixteen (16) quarters in order to permit a detailed analysis of the basic input categories of goods and services purchased by a hospital or provided to employees through wages and benefits.

Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance for Disproportionate Share Hospital Expenditures.

The Alabama Medicaid Agency uses the **CMS Form 2552** cost report, which was prepared based on Medicare cost reporting principles, as the basis for ensuring proper cost allocation and apportionment for services provided to Medicaid eligible beneficiaries and individuals with no source of third party insurance. Worksheets from the CMS Form 2552 cost report will be identified as appropriate in this Exhibit to ensure proper calculation of cost to be certified as public expenditures (CPE) for both inpatient and outpatient services, as defined in Attachment 3.1A, by hospitals. The Agency will use the protocol below.

Cost of the uninsured

1. Calculation of Interim Disproportionate Share Hospital (DSH) Limit: A base year will be used to calculate the cost of the uninsured and Medicaid eligible beneficiaries. The base year will be the State fiscal year with the most recent DSH audit being completed. The Interim DSH Limit for each hospital will be the estimated compensated care for inpatient and outpatient services to individuals with no source of third party insurance plus the uncompensated care (including potential surplus) for inpatient and outpatient services to Medicaid eligible individuals.

   This computation of establishing interim DSH payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

   a. Using the CMS Form 2552 cost report for the fiscal year ending during the fiscal year data being used (ex. 2010 data for 2012 payments), a cost to charge ratio will be determined at the facility level. The data sets used to calculate the cost to charge ratio are as follows:

CMS Form 2552-96	***CMS Form 2552-10***
Worksheet C Part I Column 1 line 103 less lines 34-36 (Total Cost)	Worksheet C Part I Column 1 line 202 less lines 44-46 (Total Cost)
Worksheet C Part I Column 6 line 103 less lines 34-36 (Inpatient Charges)	Worksheet C Part I Column 6 line 202 less lines 44-46 (Inpatient Charges)
Worksheet C Part I Column 7 line 103 less line 34-36 (Outpatient Charges)	Worksheet C Part I Column 7 line 202 less lines 44-46 (Outpatient Charges)
Worksheet C Part I Column 8 line 103 less line 34-36 (Total Charges)	Worksheet C Part I Column 8 line 202 less line 44-46 (Total Charges)

   The cost-to-charge ratio (CCR) was determined by dividing total costs by total charges, with the same CCR ratio used for inpatient and outpatient.

b. The inpatient and outpatient Medicaid hospital covered charges will be multiplied by the CCR to determine Medicaid cost. All payments made related to these Medicaid hospital covered charges would be used to offset the Medicaid cost to determine uncompensated Medicaid hospital cost.

c. The inpatient and outpatient hospital charges related to individuals with no source of third party coverage will be multiplied by the CCR to determine the cost of services to individuals with no source of third party insurance. Payments related to these individuals will be used to offset the cost of services to determine the uncompensated cost of services to individuals with no source of third party insurance.

d. The uncompensated care of hospital services for individuals with no source of third party insurance will be combined with the uncompensated Medicaid hospital cost to determine the uncompensated care cost. Any Medicaid hospital payments in excess of Medicaid hospital cost will be used to offset uncompensated care of services for individuals with no source of third party insurance.

e. The uncompensated care cost calculated will be trended by the hospital market basket index as published by Global Insight Health-Care Cost Review to determine the interim DSH limit for the reporting year payments being calculated by applying the Global Insight Health-Care Cost Review from the mid-point of the cost reporting fiscal year to the mid-point of the next State Fiscal Year and then from mid-point of the State fiscal year to the mid-point of the current State Fiscal Year.

2. Interim Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year: Upon completion of the State's reporting year, each hospital's interim payments paid under the calculations for disproportionate share hospital payments as outlined in paragraph f of Attachment 4.19-A will be reconciled to its CMS Form 2552 cost report as filed to the Medicare Administrative Contractor (MAC) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

This interim reconciliation will be completed within 10 months of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State.

Each hospital will supply the State with covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System and for services provided to individuals with no source of third party insurance (referred to as Non-Alabama Medicaid Fee for Service (FFS) Medicaid eligible activity).

Uncompensated cost of care for services provided to Medicaid eligible individuals shall be calculated as follows:

a. The hospital cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of Medicaid cost.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 22 lines 30-43, and 50-117 shall be included in the calculation of Medicaid cost.
Medicaid Routine Service Cost for Acute Services	Medicaid Routine Service Cost for Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 7, lines 7-13
Medicaid Routine Service Cost for Sub-Provider Services	Medicaid Routine Service Cost for Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 7, line 16-18.
Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

c. Combining the cost of Medicaid routine services, cost of Medicaid inpatient ancillary services, cost of Medicaid outpatient ancillary services, the cost of Medicaid organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid utilization of Medicaid charges divided by total charges less the payments received for CRNA services.

d. The payments received related to Medicaid services provided during the reporting period will be offset against total Medicaid cost of services to determine the Medicaid uncompensated care.

Uncompensated cost of care for hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSHA Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 23 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Individuals With No Source of Third Party Insurance Routine Service Cost for Acute Services	Individuals With No Source of Third Party Insurance Routine Service Cost for Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.
Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the uninsured utilization of uninsured charges divided by total charges to determine the total cost of services provided to individuals with no source of third party insurance.

d. The payments received during the reporting period related to accounts of individuals with no source of third party will be used as offset to total cost of services to determine the uncompensated cost of care of services provided to individuals with no source of third party insurance

The uncompensated care of hospital services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for hospital services provided to Medicaid eligible individuals to determine the uncompensated care cost. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of hospital services for individuals with no source of third party insurance.

The State will compare the interim reconciliation to initial DSH limit for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

e. Final Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS 2552 cost report as adjusted by the MAC for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

The final reconciliation will be completed by the end of the third CMS Form 64 quarter that follows the CMS Form 64 quarter where the of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State occurs.

If necessary, each hospital will supply the State with updated covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System and for services provided to individuals with no source of third party insurance. The State will also update any payment offset if necessary.

Uncompensated cost of care for services provided to Medicaid eligible individuals shall be calculated as follows:

a. The cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 23 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.
Medicaid FFS Medicaid Eligible Inpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid FFS Medicaid Eligible Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

c. Combining the cost of Medicaid routine services, cost of Medicaid inpatient ancillary services, cost of Medicaid outpatient ancillary services, the cost of Medicaid organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid utilization of Medicaid charges divided by total charges less the payments received for CRNA services will represent the cost of Medicaid eligible hospital services.

d. The payments received related to Medicaid hospital services provided during the reporting period will be offset against total Medicaid cost of services to determine the Medicaid uncompensated care.

Uncompensated cost of care for hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 23 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Individuals With No Source of Third Party Insurance Routine Service Cost For Acute Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, lines 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.

Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition plus the uninsured portion of CRNA expense removed on Worksheet A-8 based on the uninsured utilization based on uninsured charges divided by total charges to determine the total cost of hospital services provided to individuals with no source of third party insurance.

d. The payments received during the reporting period related to accounts of individuals with no source of third party will be used as offset to total cost of services to determine the uncompensated cost of care of services provided to individuals with no source of third party insurance.

The uncompensated care of hospital services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for services provided to Medicaid eligible individuals to determine the uncompensated care cost of hospital services. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of hospital services for individuals with no source of third party insurance.

The State will compare the final reconciliation to the interim reconciliation for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

Listing of Inpatient Access Payments and Disproportionate Share Hospital Payments

Inpatient access payments and DSH payments 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.

Inpatient Access Payments for the State Fiscal Year Ended September 30, 2014

State Owned and Operated Hospitals

Facility	Inpatient Access Payments
UNIVERSITY OF ALABAMA	59,707,266
USA CHILDRENS & WOMENS HOSPITAL	8,932,741
USA MEDICAL CTR HOSP	24,344,371
Total State Owned and Operated Hospitals	92,984,378

Non-State Government Owned and Operated Hospitals

Facility	Inpatient Access Payments
ATHENS LIMESTONE HOSP	2,790,129
GULF HEALTH HOSPITALS DBA THOMAS HOSPITAL	322,014
BAPTIST MEDICAL CENTER EAST	9,176,040
BAPTIST MEDICAL CTR SOUTH	24,437,969
BIBB MEDICAL CENTER HOSPITAL	1,217,948
BRYAN W WHITFIELD MEMORIAL H	1,946,778
CALLAHAN EYE FOUNDATION HOSPITAL	4,402
COOSA VALLEY MEDICAL CENTER	1,810,995
CULLMAN REG MEDICAL CENTER	2,401,431
D.W. MCMILLAN MEMORIAL HOSPITAL	69,431
DALE MEDICAL CENTER	341,132
DCH REGIONAL MEDICAL CENTER	8,382,898
DECATUR GENERAL HOSPITAL	2,490,010
EAST AL MEDICAL CENTER	4,469,272

Facility	Inpatient Access Payments
ECACH INC/ATMORE COMMUNITY H	219,480
GREENE COUNTY HOSPITAL	1,145,673
GROVE HILL MEMORIAL HOSPITAL	915,665
HALE COUNTY HOSPITAL	105,630
HELEN KELLER HOSPITAL	1,905,966
HIGHLANDS MEDICAL CENTER	694,160
HILL HOSPITAL OF SUMTER COUN	654,699
HUNTSVILLE HOSPITAL	9,964,993
JPAUL JONES HOSPITAL	1,379,061
LAWRENCE MEDICAL CENTER	251,433
MARSHALL MEDICAL CENTER SOUT	2,640,614
MEDICAL CENTER BARBOUR	1,830,240
MEDICAL WEST	4,016,017
MONROE COUTNY HOSPITAL	936,472
NORTH BALDWIN INFIRMARY	601,205
NORTHEAST AL REGIONAL MED CT	4,378,541
PARKWAY MEDICAL CENTER	2,416,292
PICKENS COUNTY MEDICAL CTR	711,832
PRATTVILLE BAPTIST HOSPITAL	539,682
RED BAY HOSPITAL	77,885
SOUTHEAST ALABMAM MED CTR	4,661,216
TROY REGIONAL MEDICAL CENTER	1,626,880
WASHINGTON COUTNY HOSPITAL	2,490
WEDOWEE HOSPITAL	183,136
WIREGRASS MEDICAL CENTER	547,613
Total Non-State Government Owned and Operated Hospitals	102,267,324

Privately Owned and Operated Hospitals

Facility	Inpatient Access Payments
ANDALUSIA REGIONAL HOSPITAL	3,990,633
BULLOCK COUTNY HOSPITAL	1,689,107
CHOCTAW COMMUNITY HOSPITAL	394,702
CITIZENS BAPTIST MEDICAL CTR	7,913,736
COMMUNITY HOSPITAL	2,391,836
EVERGREEN MEDICAL CENTER	1,436,994
FLORALA MEMORIAL HOSPITAL	86,576
FLOWERS HOSPITAL	11,643,691
GEORGIANA HOSPTIAL	725,321
HEALTHSOUTHLAKESHORE HOSPITAL	76,319
JACK HUGHSTON MEMORIAL HOSPITAL	1,036,368
JACKSON HOSPITAL & CLINIC	13,106,429
LAKE MARTIN COMMUNITY HOSPITAL	766,445
LV STABLER MEMORIAL HOSPITAL	1,153,425
MOBILE INFIRMARY	26,587,178
NORTHWEST MEDICAL CENTER	2,655,614
RIVERVIEW REGIONAL MED CTR	9,481,887
RUSSELL HOSPITAL	5,580,241
SHOALS HOSPITAL	2,484,355
SPRINGHILL MEM HOSP	4,327,767
ST VINCENTS EAST	11,614,723
THE CHILDRENS HOSPITAL OF ALABAMA	84,970,068
TRINITY MEDICAL CENTER	12,015,100
WALKER BAPTIST MEDICAL CENTE	11,766,024
PROFESSIONAL RESOURCES MANAGEMENT PSYCHIATRIC SERV **X**	1,265,690
LAUREL OAKS BEHAVIORAL HEALTH CEN **X**	1,404,023
MOUNTAIN VIEW HOSPITAL **X**	1,080,702
HILL CREST BEHAVIORAL HLTH S **X**	1,924,132
BAYPOINTE BEHAVIORAL HEALTH **X**	975,772
Total Privately Owned and Operated Hospitals	224,544,858

X - Privately owned and operated psychiatric hospitals

Privately Owned or Operated Disproportionate Share Hospitals

Facility	DSH Payments
BAPTIST MED CENTER – PRINCET	17,584,820
BROOKWOOD MEDICAL CENTER	9,638,674
CHEROKEE MEDICAL CENTER	1,781,512
CRENSHAW COMMUNITY HOSPITAL	1,678,193
CRESTWOOD MEDICAL CENTER	6,955,069
DEKALB REGIONAL MEDICAL CENTER	5,122,720
ELIZA COFFEE MEMORIAL HOSPIT	13,554,240
ELMORE COMMUNITY HOSPITAL	815,865
FLORALA MEMORIAL HOSPITAL	220,398
GADSDEN REGIONAL MEDICAL CTR	13,738,710
GEORGE H LANIER MEMORIAL HOS	3,050,666
JACKSON MEDICAL CENTER	1,626,969
LAKELAND COMMUNITY HOSPITAL	2,250,346
MARION REGIONALMEDICAL CENTE	1,434,038
MIZELL MEMORIAL HOSPITAL	1,611,782
PROVIDENCE HOSPITAL	13,405,106
QHG OF ENTERPRISE INC	4,862,051
RUSSELLVILLE HOSPITAL	6,424,464
SHELBY BAPTIST MEDICAL CENTE	14,810,456
SOUTH BALDWIN REGIONAL MED C	5,761,895
SPRINGHILL MEM HOSP	1,717,510
ST VINCENTS BLOUNT	2,581,742
ST VINCENTS EAST	739,894
ST VINCENTS HOSPITAL	9,216,258
ST VINCENTS ST CLAIR	2,121,849
STRINGFELLOW MEM HOSP	4,811,552
TRINITY MEDICAL CENTER	785,561
VAUGHAN REG MED CTR PARKWAY CAMPU	9,461,712

NOTE: State owned and operated hospitals and non-State government owned and operated hospitals initial DSH payments will be determined with the CPE estimate in Exhibit C of this attachment and final payments will be determined through the DSH audit process and the CPE reconciliations in Exhibit C of this attachment.

EXHIBIT A

LOW OCCUPANCY ADJUSTMENT FOR URBAN HOSPITALS

$$LOA = \left(1 - \frac{TBD}{YABD}\right) ACC$$

TBD = Total Bed Days Actually Used During the Cost Report Period Exclusive of Nursery Bassinets and/or Separately Certified non-Covered Units (i.e. Psych.).

ABD = Available Bed Days Which is Determined by Multiplying the Total Licensed Beds Times the Number of Days in the Cost Report Period Exclusive of Nursery Bassinets and/or Separately Certified non covered Units (i.e. psych.)

ACC = Allowable Capital Costs

Y = Occupancy Factor

(Y = 70% 100 beds or less)
(Y = 80% 101 beds or less)

EXHIBIT B
Page 1

NATIONAL MARKET BASKET PRICE PROXIES
HOSPITAL INPATIENT OPERATING COSTS

EXPENSE CATEGORY	RELATIVE WEIGHT*	HCFA-DESIGNATED PRICE VARIABLE
Wages & Salaries	57.24	Average Hourly Earnings, Hospital Workers (SIC 806)
Employee Benefits	8.22	Supplements to Wages and Salaries per Employee in Nonagricultural Establishments
Professional Fees, Medical	--	Consumer Price Index, All Urban Physicians' Services
Professional Fees, Other	0.59	Index of Hourly Earnings of Production Workers, Private Nonfarm
Malpractice Insurance Premiums	1.96	Hospital Malpractice Insurance Premiums
Food	3.56	a. Consumer Price Index, All Urban, Food and Beverages b. Producer Price Index, Processed Food and Feeds
Fuel & Other Utilities	2.76	a. Implicit Price Deflator, Consumption of Fuel Oil and Coal b. Implicit Price Deflator Consumption of Electricity c. Implicit Price Deflator Consumption of Natural Gas d. Consumer Price Index, All Urban, Water and Sewerage Maintenance
Drugs	2.82	Producer Price Index, Preparations, Ethical (Prescription)

Chemicals and Cleaning Products	2.15	Producer Price Index, Chemicals and Allied Products
Surgical and Medical Instruments and Supplies	2.03	Producer Price Index, Special Industry Machinery and Equipment
Rubber and Miscellaneous Plastics	1.84	Producer Price Index, Rubber and Plastic Products
Business Travel & Motor Freight	1.72	Producer Price Index, Textile Products and Apparel
Apparel and Textiles	1.65	Consumer Price Index, Textile Products and Apparel
Business Services	4.70	Consumer Price Index, All Urban, Services
All Other Miscellaneous	8.76	Consumer Price Index, All Urban, All Items
	100.0	

*HCFA input price index excludes capital, medical education, and medical professional fees. Weights are based on HCFA special studies.

The above relative weights are per Data Resources, Inc. (Health Care Costs) Volume V, Number 7, 3rd Quarter 1985 Series.

EXHIBIT B
Page 3

The National Hospital Input Price Index methodology will be utilized to isolate the effects of prices of goods and services for Alabama hospitals. Such an index will measure the average percent change in prices for a fixed "market basket" of hospital categories of expenses as forecasted by Data Resources, Inc. (Data Resources, Inc., Cost Forecasting Service, Regional Forecasting Models for Selected Components of the Hospital and Nursing Home Cost Index, 1750 K Street, Washington, DC 20006). Such a forecast combined with the historical period data, will provide a price index for hospital inpatient reimbursement in the state.

The National Hospital Input Price Index was developed utilizing a fixed set of weights for each of seven (7) categories of expenses. The article by Freeland, et al., in the HCFA Review (Summer 1979) discussed the various "market basket" comparisons, input-output data, and other survey designs which were utilized in the establishment of the Price Index. These were further refined by Data Resources, Inc., to provide a total of fourteen (14) basic Expense Categories. Relative cost weights were established from 1977 data to establish the final National Market Basket Price Proxies published in Health Care Costs (Data Resources, Inc., Vol. 1, No. 1, May 1981). This publication will provide market basket forecasts for a total of sixteen (16) quarters in order to permit a detailed analysis of the basic input categories of goods and services purchased by a hospital or provided to employees through wages and benefits.

Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance for Disproportionate Share Hospital Expenditures.

The Alabama Medicaid Agency uses the **CMS Form 2552** cost report, which was prepared based on Medicare cost reporting principles, as the basis for ensuring proper cost allocation and apportionment for services provided to Medicaid eligible beneficiaries and individuals with no source of third party insurance. Worksheets from the CMS Form 2552 cost report will be identified as appropriate in this Exhibit to ensure proper calculation of cost to be certified as public expenditures (CPE) for both inpatient and outpatient services, as defined in Attachment 3.1A, by hospitals. The Agency will use the protocol below.

Cost of the uninsured

1. Calculation of Interim Disproportionate Share Hospital (DSH) Limit: A base year will be used to calculate the cost of the uninsured and Medicaid eligible beneficiaries. The base year will be the State fiscal year with the most recent DSH audit being completed. The Interim DSH Limit for each hospital will be the estimated compensated care for inpatient and outpatient services to individuals with no source of third party insurance plus the uncompensated care (including potential surplus) for inpatient and outpatient services to Medicaid eligible individuals.

   This computation of establishing interim DSH payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

   a. Using the CMS Form 2552 cost report for the fiscal year ending during the fiscal year data being used (ex. 2010 data for 2012 payments), a cost to charge ratio will be determined at the facility level. The data sets used to calculate the cost to charge ratio are as follows:

CMS Form 2552-96	***CMS Form 2552-10***
Worksheet C Part I Column 1 line 103 less lines 34-36 (Total Cost)	Worksheet C Part I Column 1 line 202 less lines 44-46 (Total Cost)
Worksheet C Part I Column 6 line 103 less lines 34-36 (Inpatient Charges)	Worksheet C Part I Column 6 line 202 less lines 44-46 (Inpatient Charges)
Worksheet C Part I Column 7 line 103 less line 34-36 (Outpatient Charges)	Worksheet C Part I Column 7 line 202 less lines 44-46 (Outpatient Charges)
Worksheet C Part I Column 8 line 103 less line 34-36 (Total Charges)	Worksheet C Part I Column 8 line 202 less line 44-46 (Total Charges)

   The cost-to-charge ratio (CCR) was determined by dividing total costs by total charges, with the same CCR ratio used for inpatient and outpatient.

b. The inpatient and outpatient Medicaid hospital covered charges will be multiplied by the CCR to determine Medicaid cost. All payments made related to these Medicaid hospital covered charges would be used to offset the Medicaid cost to determine uncompensated Medicaid hospital cost.

c. The inpatient and outpatient hospital charges related to individuals with no source of third party coverage will be multiplied by the CCR to determine the cost of services to individuals with no source of third party insurance. Payments related to these individuals will be used to offset the cost of services to determine the uncompensated cost of services to individuals with no source of third party insurance.

d. The uncompensated care of hospital services for individuals with no source of third party insurance will be combined with the uncompensated Medicaid hospital cost to determine the uncompensated care cost. Any Medicaid hospital payments in excess of Medicaid hospital cost will be used to offset uncompensated care of services for individuals with no source of third party insurance.

e. The uncompensated care cost calculated will be trended by the hospital market basket index as published by Global Insight Health-Care Cost Review to determine the interim DSH limit for the reporting year payments being calculated by applying the Global Insight Health-Care Cost Review from the mid-point of the cost reporting fiscal year to the mid-point of the next State Fiscal Year and then from mid-point of the State fiscal year to the mid-point of the current State Fiscal Year.

2. Interim Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year: Upon completion of the State's reporting year, each hospital's interim payments paid under the calculations for disproportionate share hospital payments as outlined in paragraph f of Attachment 4.19-A will be reconciled to its CMS Form 2552 cost report as filed to the Medicare Administrative Contractor (MAC) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

This interim reconciliation will be completed within 10 months of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State.

Each hospital will supply the State with covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System and for services provided to individuals with no source of third party insurance (referred to as Non-Alabama Medicaid Fee for Service (FFS) Medicaid eligible activity).

Uncompensated cost of care for services provided to Medicaid eligible individuals shall be calculated as follows:

a. The hospital cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of Medicaid cost.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 22 lines 30-43, and 50-117 shall be included in the calculation of Medicaid cost.
Medicaid Routine Service Cost for Acute Services	Medicaid Routine Service Cost for Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 7, lines 7-13
Medicaid Routine Service Cost for Sub-Provider Services	Medicaid Routine Service Cost for Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 7, line 16-18.
Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

c. Combining the cost of Medicaid routine services, cost of Medicaid inpatient ancillary services, cost of Medicaid outpatient ancillary services, the cost of Medicaid organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid utilization of Medicaid charges divided by total charges less the payments received for CRNA services.

d. The payments received related to Medicaid services provided during the reporting period will be offset against total Medicaid cost of services to determine the Medicaid uncompensated care.

Uncompensated cost of care for hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSHA Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 23 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Individuals With No Source of Third Party Insurance Routine Service Cost for Acute Services	Individuals With No Source of Third Party Insurance Routine Service Cost for Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.
Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the uninsured utilization of uninsured charges divided by total charges to determine the total cost of services provided to individuals with no source of third party insurance.

d. The payments received during the reporting period related to accounts of individuals with no source of third party will be used as offset to total cost of services to determine the uncompensated cost of care of services provided to individuals with no source of third party insurance

The uncompensated care of hospital services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for hospital services provided to Medicaid eligible individuals to determine the uncompensated care cost. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of hospital services for individuals with no source of third party insurance.

The State will compare the interim reconciliation to initial DSH limit for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

e. Final Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS 2552 cost report as adjusted by the MAC for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

The final reconciliation will be completed by the end of the third CMS Form 64 quarter that follows the CMS Form 64 quarter where the of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State occurs.

If necessary, each hospital will supply the State with updated covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System and for services provided to individuals with no source of third party insurance. The State will also update any payment offset if necessary.

Uncompensated cost of care for services provided to Medicaid eligible individuals shall be calculated as follows:

a. The cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 23 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.
Medicaid FFS Medicaid Eligible Inpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid FFS Medicaid Eligible Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

c. Combining the cost of Medicaid routine services, cost of Medicaid inpatient ancillary services, cost of Medicaid outpatient ancillary services, the cost of Medicaid organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid utilization of Medicaid charges divided by total charges less the payments received for CRNA services will represent the cost of Medicaid eligible hospital services.

d. The payments received related to Medicaid hospital services provided during the reporting period will be offset against total Medicaid cost of services to determine the Medicaid uncompensated care.

Uncompensated cost of care for hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 23 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Individuals With No Source of Third Party Insurance Routine Service Cost For Acute Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, lines 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.

Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition plus the uninsured portion of CRNA expense removed on Worksheet A-8 based on the uninsured utilization based on uninsured charges divided by total charges to determine the total cost of hospital services provided to individuals with no source of third party insurance.

d. The payments received during the reporting period related to accounts of individuals with no source of third party will be used as offset to total cost of services to determine the uncompensated cost of care of services provided to individuals with no source of third party insurance.

The uncompensated care of hospital services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for services provided to Medicaid eligible individuals to determine the uncompensated care cost of hospital services. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of hospital services for individuals with no source of third party insurance.

The State will compare the final reconciliation to the interim reconciliation for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

Listing of Inpatient Access Payments and Disproportionate Share Hospital Payments

Inpatient access payments and DSH payments 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.

Inpatient Access Payments for the State Fiscal Year Ended September 30, 2014

State Owned and Operated Hospitals

Facility	Inpatient Access Payments
UNIVERSITY OF ALABAMA	59,707,266
USA CHILDRENS & WOMENS HOSPITAL	8,932,741
USA MEDICAL CTR HOSP	24,344,371
Total State Owned and Operated Hospitals	92,984,378

Non-State Government Owned and Operated Hospitals

Facility	Inpatient Access Payments
ATHENS LIMESTONE HOSP	2,790,129
GULF HEALTH HOSPITALS DBA THOMAS HOSPITAL	322,014
BAPTIST MEDICAL CENTER EAST	9,176,040
BAPTIST MEDICAL CTR SOUTH	24,437,969
BIBB MEDICAL CENTER HOSPITAL	1,217,948
BRYAN W WHITFIELD MEMORIAL H	1,946,778
CALLAHAN EYE FOUNDATION HOSPITAL	4,402
COOSA VALLEY MEDICAL CENTER	1,810,995
CULLMAN REG MEDICAL CENTER	2,401,431
D.W. MCMILLAN MEMORIAL HOSPITAL	69,431
DALE MEDICAL CENTER	341,132
DCH REGIONAL MEDICAL CENTER	8,382,898
DECATUR GENERAL HOSPITAL	2,490,010
EAST AL MEDICAL CENTER	4,469,272

Facility	Inpatient Access Payments
ECACH INC/ATMORE COMMUNITY H	219,480
GREENE COUNTY HOSPITAL	1,145,673
GROVE HILL MEMORIAL HOSPITAL	915,665
HALE COUNTY HOSPITAL	105,630
HELEN KELLER HOSPITAL	1,905,966
HIGHLANDS MEDICAL CENTER	694,160
HILL HOSPITAL OF SUMTER COUN	654,699
HUNTSVILLE HOSPITAL	9,964,993
JPAUL JONES HOSPITAL	1,379,061
LAWRENCE MEDICAL CENTER	251,433
MARSHALL MEDICAL CENTER SOUT	2,640,614
MEDICAL CENTER BARBOUR	1,830,240
MEDICAL WEST	4,016,017
MONROE COUTNY HOSPITAL	936,472
NORTH BALDWIN INFIRMARY	601,205
NORTHEAST AL REGIONAL MED CT	4,378,541
PARKWAY MEDICAL CENTER	2,416,292
PICKENS COUNTY MEDICAL CTR	711,832
PRATTVILLE BAPTIST HOSPITAL	539,682
RED BAY HOSPITAL	77,885
SOUTHEAST ALABMAM MED CTR	4,661,216
TROY REGIONAL MEDICAL CENTER	1,626,880
WASHINGTON COUTNY HOSPITAL	2,490
WEDOWEE HOSPITAL	183,136
WIREGRASS MEDICAL CENTER	547,613
Total Non-State Government Owned and Operated Hospitals	102,267,324

Privately Owned and Operated Hospitals

Facility	Inpatient Access Payments
ANDALUSIA REGIONAL HOSPITAL	3,990,633
BULLOCK COUTNY HOSPITAL	1,689,107
CHOCTAW COMMUNITY HOSPITAL	394,702
CITIZENS BAPTIST MEDICAL CTR	7,913,736
COMMUNITY HOSPITAL	2,391,836
EVERGREEN MEDICAL CENTER	1,436,994
FLORALA MEMORIAL HOSPITAL	86,576
FLOWERS HOSPITAL	11,643,691
GEORGIANA HOSPTIAL	725,321
HEALTHSOUTHLAKESHORE HOSPITAL	76,319
JACK HUGHSTON MEMORIAL HOSPITAL	1,036,368
JACKSON HOSPITAL & CLINIC	13,106,429
LAKE MARTIN COMMUNITY HOSPITAL	766,445
LV STABLER MEMORIAL HOSPITAL	1,153,425
MOBILE INFIRMARY	26,587,178
NORTHWEST MEDICAL CENTER	2,655,614
RIVERVIEW REGIONAL MED CTR	9,481,887
RUSSELL HOSPITAL	5,580,241
SHOALS HOSPITAL	2,484,355
SPRINGHILL MEM HOSP	4,327,767
ST VINCENTS EAST	11,614,723
THE CHILDRENS HOSPITAL OF ALABAMA	84,970,068
TRINITY MEDICAL CENTER	12,015,100
WALKER BAPTIST MEDICAL CENTE	11,766,024
PROFESSIONAL RESOURCES MANAGEMENT PSYCHIATRIC SERV **X**	1,265,690
LAUREL OAKS BEHAVIORAL HEALTH CEN **X**	1,404,023
MOUNTAIN VIEW HOSPITAL **X**	1,080,702
HILL CREST BEHAVIORAL HLTH S **X**	1,924,132
BAYPOINTE BEHAVIORAL HEALTH **X**	975,772
Total Privately Owned and Operated Hospitals	224,544,858

X - Privately owned and operated psychiatric hospitals

Privately Owned or Operated Disproportionate Share Hospitals

Facility	DSH Payments
BAPTIST MED CENTER – PRINCET	17,584,820
BROOKWOOD MEDICAL CENTER	9,638,674
CHEROKEE MEDICAL CENTER	1,781,512
CRENSHAW COMMUNITY HOSPITAL	1,678,193
CRESTWOOD MEDICAL CENTER	6,955,069
DEKALB REGIONAL MEDICAL CENTER	5,122,720
ELIZA COFFEE MEMORIAL HOSPIT	13,554,240
ELMORE COMMUNITY HOSPITAL	815,865
FLORALA MEMORIAL HOSPITAL	220,398
GADSDEN REGIONAL MEDICAL CTR	13,738,710
GEORGE H LANIER MEMORIAL HOS	3,050,666
JACKSON MEDICAL CENTER	1,626,969
LAKELAND COMMUNITY HOSPITAL	2,250,346
MARION REGIONALMEDICAL CENTE	1,434,038
MIZELL MEMORIAL HOSPITAL	1,611,782
PROVIDENCE HOSPITAL	13,405,106
QHG OF ENTERPRISE INC	4,862,051
RUSSELLVILLE HOSPITAL	6,424,464
SHELBY BAPTIST MEDICAL CENTE	14,810,456
SOUTH BALDWIN REGIONAL MED C	5,761,895
SPRINGHILL MEM HOSP	1,717,510
ST VINCENTS BLOUNT	2,581,742
ST VINCENTS EAST	739,894
ST VINCENTS HOSPITAL	9,216,258
ST VINCENTS ST CLAIR	2,121,849
STRINGFELLOW MEM HOSP	4,811,552
TRINITY MEDICAL CENTER	785,561
VAUGHAN REG MED CTR PARKWAY CAMPU	9,461,712

NOTE: State owned and operated hospitals and non-State government owned and operated hospitals initial DSH payments will be determined with the CPE estimate in Exhibit C of this attachment and final payments will be determined through the DSH audit process and the CPE reconciliations in Exhibit C of this attachment.

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

Alabama Medicaid uses a Prospective Payment System (PPS) for RHCs as required by S.S.A. §1902(a)(15) [42 U.S.C. § 1396a (a)(15)] and S.S.A. §1902(bb) [42 U.S.C. §1396a(bb)]. The PPS for RHCs was implemented and took effect on January 1, 2001.

A. Prospective Payment System (PPS) rates

The baseline Prospective Payment System (PPS) for each RHC in FY2002 was developed by weighing the RHC's provider specific reasonable costs for Fiscal Years 1999 and 2000 by the number of Medicaid encounters provided in each year. The RHC is entitled to the previous year's PPS, increased by the percentage increase by 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.

Prospective Payment System (PPS) Reimbursement for New Facilities

The rate established for a new RHC shall be equal to 100% of the reasonable cost used in calculating the rates of like RHCs located in the same or an adjacent area during the same fiscal year. The costs that must be considered in calculating the payment rate are those reasonable costs used in calculating the rates for neighboring clinics with similar caseloads.

Change in Scope of Services

The PPS rate for a RHC shall be adjusted to take into account a change (either increase or decrease) in the scope of services furnished by the RHC. A change in scope of services occurs if the RHC has added or dropped any service that meets the definition of RHC services as provided in section 1905(a)(2)(B) and (C) of the Social Security Act or if the service is included as a covered Medicaid service in the state plan. A change in the scope of services is defined as a change in the type, intensity, duration, and/or amount of services provided during a RHC visit. A change in the cost of a service is not considered in and of itself a change in the scope of services.

1. Rural Health Clinic (continued)

A. Bonus Payment

Beginning October 1, 2024, RHCs that are Alabama Coordinated Health Network (ACHN) Certified are eligible to receive a bonus payment in addition to the PPS rate, but only if they meet ACHN bonus payment criteria.

ACHN Certified Maternity Care Provider (MCP) Enhanced Payment

ACHN Certified MCPs will receive an enhanced payment for:

i. an initial prenatal visit in the first trimester and/or
ii. post-partum visits.

ACHN Certified Provider Performance Payments

Performance Payments for ACHN Certified Primary Care Provider (PCP) Groups:
A performance payment pool will be established in the amount of $20 million annually to fund three (3) performance payments for ACHN Certified PCP groups. The performance payments' pool is allotted as follows: 50% for quality, 45% for cost effectiveness, and 5% for PCMH Recognition.

a. Quality Performance Payments
   a. Eligibility: All ACHN Certified PCP groups will be eligible for a performance payment if the PCP group meets the requirements described below.
   b. Methodology:
      i. ACHN Certified PCP groups that achieve annual performance benchmarks determined by the Agency are eligible to receive performance payments.
      ii. Benchmarks will be posted at www.medicaid.alabama.gov by September 2024 and will be updated annually at least 30 days prior to the contract period.
      iii. The quality benchmarks will be posted to: www.medicaid.alabama.gov
      Click the ACHN tab/Provider.
      iv. The amount available for the quarterly quality payment will be one-quarter (1/4) of the annual amount described above.
      v. The first payment will be made in October 2024. Subsequent payments will be made on a quarterly basis.
      vi. Level One Quality Performance Payment for the period between October 1, 2024 and March 31, 2026:
         1. The Agency will make quarterly payments in the first month of the quarter based on provider reporting of necessary data and other activities including provider engagement in the ACHN and their review and response to quality data provided by the Agency, implementing any policies and processes to improve the efficiency of their practices, and engaging with the ACHNs in preparation to be paid based on performance-based quality payments. Providers will also be readjusting their practice guidelines to manage attributed patient populations rather than Agency assigned panels.
         2. Payments made in this period are based on the engagement by the PCP group and not for the achievement of quality measurements.
         3. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.
      vii. Level Two Quality Performance Payment for the period of April 1, 2026 and beyond:
         1. The Agency's quarterly payments beginning with the April 2026 payment will be based on actual quality measure performance calculated for the services rendered for the previous 12 months with a 9-month time lag on a rolling basis. For example, the quarterly payments made during April 2026, will be based on the actual quality measure performance calculated for the period between July 1, 2024, and June 30, 2025. Similarly, the quality measure payments made during July 2026, will be based on the quality measure performance calculated for the period between October 1, 2024, and September 30, 2025.

1. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

b. Cost Effectiveness Performance Payments

a. Eligibility: All ACHN Certified PCP groups will be eligible for a performance payment if the PCP group meets or exceeds the cost effectiveness criteria established by the Agency.

b. Methodology:

i. ACHN Certified PCP groups that achieve annual performance benchmarks determined by the Agency are eligible to receive performance payments.

ii. Benchmarks will be posted at www.medicaid.alabama.gov by September 1, 2019 and will be updated annually at least 30 days prior to the contract period.

iii. The cost effectiveness performance payment criteria will be posted to: www.medicaid.alabama.gov
Click the ACHN tab/Provider

iv. The amount available for the quarterly cost effectiveness payment will be one-quarter (1/4) of the annual amount described above.

v. The first payment will be made in October 2019. Subsequent payments will be made on a quarterly basis.

vi. Level One Cost Effectiveness Performance Payment for the period between October 1, 2019 and December 31, 2020:

1. The Agency will make quarterly payments in the first month of the quarter for review and response to cost effectiveness data provided by the Agency, implementing any policies and processes to improve the efficiency of their practices, and engaging with the ACHNs in preparation to be paid based on performance-based cost effectiveness payments. Providers will also be readjusting their practice guidelines to manage attributed patient populations rather than Agency assigned panels.
2. Payments made in this period are based on the engagement by the PCP group and not for the achievement of cost effectiveness measurements.
3. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

vii. Level Two Cost Effectiveness Performance Payment for the period of January 1, 2021 and beyond:

1. The Agency's quarterly payments beginning with the January 2021 payment will be based on actual cost effectiveness performance.
   1. The cost effectiveness performance calculation compares a 12-month per member per month (PMPM) to a risk-adjusted expected PMPM based on the costs of similar PCP groups that treat Medicaid recipients. Groups will be ranked by an efficiency score that is derived from actual PMPM versus the expected PMPM. Performance payment will be made for PCP groups that meet a cost effectiveness score of less than 1.0.
2. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

Patient Centered Medical Home (PCMH) Performance Payments

The purpose of the PCMH Recognition performance payment is to incentivize providers to attain PCMH Recognition thereby ensuring Medicaid Recipients are receiving care through a nationally recognized medical home model.

1. Eligibility: All ACHN Certified PCP groups who receive PCMH recognition as described below.
2. Methodology:
   i. PCMH Recognition information may be obtained at: www.medicaid.alabama.gov Click the ACHN tab/Provider
   ii. The PCP group can obtain PCMH Recognition or certification through a nationally recognized entity such as National Committee for Quality Assurance (NCQA). Details from NCQA can be found at https://www.ncqa.org/programs/helath-care-providers-practices/patient-centered-medical-home-pcmh.
   iii. The amount available for the quarterly PCMH Recognition payment will be one-quarter (1/4) of the annual amount described above.
   iv. The first payment will be made in October 2019. Subsequent payments will be made on a quarterly basis.
   v. Level One PCMH Performance Payment for the period between October 1, 2019 and September 30, 2020:

The Agency will make quarterly payments in the first month of the quarter for PCMH Recognition performance payments.

   a. Payments made in this period are for PCP groups that have already obtained the Recognition or certification and PCP groups that are progressing toward attainment of Recognition or certification. To be eligible for the PCMH Recognition performance payment, PCP groups must attest to the status of their attainment of PCMH Recognition or to their progress towards attainment.
   b. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

   vii. Level Two PCMH Performance Payment for the period October 1, 2020 and beyond

   a. Payments made in this period are for PCP groups that attest they have obtained the Recognition or certification. The Agency will review the PCP groups attestation on an annual basis on the last business day of the month prior to the first quarterly payment for the ensuing year. For example, the quarterly payments made in October 2020, January 2021, April 2021, and July 2021 will be based on the PCP groups attestation of their achievement of recognition or certification as of the last business day in September 2020.
   b. The amount of the performance payment distributed to each PCP group will be based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.
   c. If a PCP group does not meet PCMH Recognition and does not show adequate progress toward meeting recognition, the Agency will not pay the PCMH performance payment.

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: 01/01/2020

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 procedures 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 rates were set as of October 1, 2018 and are effective for services provided on or after that date. All rates are published and maintained on the Agency's website at www.medicaid.alabama.gov. For the most recent Physician Service Fee Schedule click on the Providers tab, select Fee Schedules, check "I Accept" on the User Agreement, and select Physician Fee Schedule.

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 www.medicaid.alabama.gov To view a Rural Physician Fee Schedule visit http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules/7.3G_Rural_Physician_Fee_Schedule_5-27-15.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. Supplemental Payments for Qualifying Physicians and Professional Services:

Physician Access (Enhanced) Payments – Teaching Physicians

Qualifying Criteria:

In order to maintain adequate access to specialty faculty physician (all specialties including general practice, family practice, and general pediatrics) services as required, supplemental payments will be made for services provided to Medicaid recipients by eligible physicians and other professional services practitioners.

To qualify for the supplemental payments, eligible physicians and other professional service practitioners must:

1. Be enrolled as one of the following provider types:
   a. Physicians (as defined in state plan)
   b. Physician Assistants
   c. Nurse Practitioners (NPs)
   d. Certified Nurse Midwives (CNM)
   e. Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs)
   f. Clinical Psychologists
   g. Optometrists

2. Be in a hospital sponsored location as an approved place of service:
   a. Inpatient hospital
   b. Outpatient hospital
   c. Hospital-based clinic
   d. Hospital affiliated clinic
3. Be licensed by the State of Alabama, have an Alabama Medicaid provider agreement and be employed by or under contract with a medical school that is part of the public university system or a children's hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Services Act (42 U.S.C. 256e) and which operates and maintains a state license for specialty pediatric beds. Participants that qualify under this subsection are:
   a. The University of Alabama System
   b. The University of South Alabama
   c. Children's of Alabama

   The services listed below do not qualify under the Physician Access (Enhanced) Payments Teaching Physicians:
      a) Clinical diagnostic lab procedures
      b) Technical component of radiology services
      c) Services provided to dual eligibles
      d) EPSDT
      e) Injectables

Supplemental Payment Methodology

4. Calculation of total Medicare equivalent payment rate - Teaching Physicians
   a. Recognize the non-facility Medicare physician fee schedule for the most recent full calendar year.
   b. Obtain the rates paid by the top five commercial insurance companies in Alabama for each public university system and children's hospital healthcare system for the calendar year ending December 31, 2021 and calculate the average commercial rate by CPT for each hospital.
   c. Obtain the units paid during the calendar year from the MMIS system for each procedure code in 4a.
   d. Anesthesia payment is based on a fifteen minutes unit of service as well as a base payment.
   e. Calculate the aggregate commercial payment equivalent for the most recent full calendar year by multiplying the Medicaid units identified in 4c above by the commercial rates identified in 4b, then combine the payments for all services. This produces the total commercial equivalent payment amount.
   f. Calculate the Medicare equivalent payments for the most recent full calendar year by multiplying the Medicaid units in 4c above by the Medicare rates identified in 4a, then combine the payments for all services. This produces the total Medicare equivalent payment amount.
   g. Divide the total commercial payment amount by the total Medicare equivalent payment amount to determine the Medicare equivalent payment percentage.
   h. Multiply the Medicare equivalent payment percentage from 4f above times the Medicare fee schedule rates in 4a to determine the Medicare equivalent rates.
   i. Based on the demonstration for calendar year 2021 Medicaid utilization and the 2021 Medicare based rates, the established teaching physician percentage is 199.23%.
   j. Reimbursement rates for numeric procedure codes not recognized by Medicare, but recognized by the Alabama Medicaid Agency will be the weighted 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 the Qualifying Criteria above, for the most recent full calendar year.

5. Calculation of quarterly supplemental payments – Teaching Physicians
   a. Each quarter Alabama Medicaid will query its MMIS for paid Medicaid claims for participants as defined in *Qualifying Criteria* listed above for the preceding quarter to determine units paid and amounts allowed during the quarter.
   b. Supplemental payments will be paid on the difference between the actual paid claim amounts in 5a above and the Medicare rates of those claims multiplied by the Medicare Equivalent of the ACR percentage determined in 4i above.
   c. Obtain the Medicare rate (from the non-facility Medicare physician fee schedule for the most recent full calendar year) for each code identified in 5a and multiply them by the Medicare Equivalent of the ACR percentage identified in 4i.
   d. Multiply the Medicare equivalent rates in 5c by the Medicaid units in 5a for each provider to determine the enhanced payment per code.
   e. The amount Medicaid allowed for the claims in 5a is subtracted from 5d above to establish the total allowable quarterly supplemental payment amount for the participants in 1 above.

Non-state governmental entity (Specifically a health care authority or a wholly owned subsidiary thereof - Physician Retention and Access Improvement Program [PRAIP])

Qualifying Criteria
In order to maintain adequate access to specialty physicians (all specialties, including general practice, family practice, and general pediatrics) services as required, supplemental payments will be made for services provided to Medicaid recipients by eligible physicians and other professional services practitioners.

To qualify for the supplemental payments, eligible physicians and other professional service practitioners must:

1. Be one of the following provider types:
   a. Physicians (as defined in state plan)
   b. Physician Assistants
   c. Nurse Practitioners (NPs)
   d. Certified Nurse Wives (CNMs)
   e. Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs)
   f. Clinical Psychologists
   g. Optometrists

2. Be in a hospital-sponsored location as an approved place of service:
   a. Inpatient hospital
   b. Outpatient hospital
   c. Hospital-based clinic
   d. Hospital affiliated clinic

3. Be licensed by the State of Alabama, have an Alabama Medicaid provider agreement and be employed by or under contract with a non-state governmental entity, specifically a health care authority or a wholly owned subsidiary thereof; and be a participant in the PRAIP. Participants that qualify under this subsection effective 1/1/2025:
   a) The Health Care Authority for Baptist Health an Affiliate of UAB Health System

b) The Health Group of Alabama, LLC, a wholly owned subsidiary of The Health Care Authority of The City of Huntsville, Alabama
c) Houston County Health Care Authority D/B/A as Southeast Alabama Medical Center
d) The East Alabama Healthcare Authority
e) The Health Care Authority of the City of Anniston dba Northeast Alabama Regional Medical Center
f) The Sylacauga Healthcare Authority

The services listed below do not qualify under PRAIP:

a. Clinical diagnostic lab procedures
b. Technical component of radiology services
c. Services provided to dual eligibles
d. EPSDT
e. Injectables

Supplemental Payment Methodology

4. Calculation of the quarterly supplemental payment - PRAIP

a) Recognize the non-facility Medicare physician fee schedule for the most recent full calendar year.
b) Obtain the rates paid by the top five commercial insurance companies in Alabama for each PRAIP participant for the calendar year ending December 31, 2023 and calculate the average commercial rate by CPT for each participant.
c) Obtain the units paid during the calendar year from the MMIS system for each procedure code in 4a.
d) Anesthesia payment is based on a fifteen-minute unit of service as well as a base payment.
e) Calculate the aggregate commercial payment equivalent for the most recent full calendar year by multiplying the Medicaid units identified in 4c above by the commercial rates identified in 4b, then combine the payments for all services. This produces the total commercial equivalent payment amount.
f) Calculate the Medicare equivalent payments for the most recent full calendar year by multiplying the Medicaid units in 4c above by the Medicare rates identified in 4a, then combine the payments for all services. This produces the total Medicare equivalent payment amount.
g) Divide the total commercial payment amount by the total Medicare equivalent payment amount to determine the Medicare equivalent payment percentage.
h) Multiply the Medicare equivalent payment percentage from 4f above times the Medicare fee schedule rates in 4a to determine the Medicare equivalent rates.
i) Each PRAIP participant will have a percentage based on the demonstration for calendar year 2023 Medicaid utilization and the 2023 Medicare based rates. Participants that qualify and their percentages of Medicare under this subsection are:

1. The Health Group of Alabama, LLC, A Wholly Owned Subsidiary of The Health Care Authority of The City of Huntsville, Alabama, 125.78%
2. Houston County Health Care Authority d/b/a Southeast Alabama Medical Center, 103.72%
3. The Health Care Authority for Baptist Health an Affiliate of UAB Health System, 134.68%
4. The East Alabama Healthcare Authority 117.38%
5. The Health Care Authority of the City of Anniston dba Northeast Alabama Regional Medical Center 104.51%
6. The Sylacauga Healthcare Authority 172.57%

5. Calculation of quarterly supplemental payments - PRAIP
   a) Each quarter Alabama Medicaid will query its MMIS for paid Medicaid claims for each PRAIP participant as defined in *Qualifying Criteria* listed above for the preceding quarter to determine units paid and allowed during the quarter.
   b) Supplemental payments will be paid on the difference between the actual paid claim amounts in 5a above and the Medicare rates of those claims multiplied by the Medicare Equivalent percentage determined in 4i above.
   c) Obtain the Medicare rate (from the non-facility Medicare physician fee schedule for the most recent full calendar year) for each code identified in 5a and multiply them by the Medicare Equivalent percentage identified in 4i.
   d) Multiply the Medicare equivalent rates in 5c by the Medicaid units in 5a for each provider to determine the enhanced payment per code.
   e) The amount Medicaid allowed for the claims in 5a is subtracted from 5d above to establish the total allowable quarterly supplemental payment amount for the participants in 1 above.

3. Primary Care (Enhanced) Rates "Bump":

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 and there is no signed Alabama Coordinated Health Network (ACHN) agreement on file for ACHN certified Primary Care Physicians (PCPs). 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.

Payment Methodology

I. Applies to E&M billing codes 99202 through 99499 that are considered reimbursable by Alabama Medicaid.

II. Applies to Vaccine Administration

a. 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 VFC program.

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

The Primary Care (Enhanced) Rates "Bump" fee schedule is effective October 1, 2019. All rates are published on the Agency's website at www.medicaid.alabama.gov. To view the Primary Care (Enhanced) Rates "Bump" fee schedule visit: www.medicaid.alabama.gov

a. click Providers tab
b. click fee schedules
c. click Physicians Primary Care Enhanced Bump Rates

4. Higher Levels of Service Defined by Engagement of ACHN Certified PCP Groups with the ACHN Program: ACHN Certified PCP group may earn higher payment levels (Certified Rates) on 13 E&M codes (refer to 1 (a) under Payment Methodology) and Performance payments (Section III) if they provide a higher level of service by engaging with the ACHN as follows:

a. Over a twelve (12) month period, attending in person, or virtual in at least three (3) quarterly Medical Management Meetings with the ACHN's Medical Director. Attendance requirements can be met by having one PCP or Nurse Practitioner/Physician Assistant from the group attend;
b. Engagement in ACHN initiatives centered around quality measures;
c. Reviewing data provided by the ACHN to help achieve Agency and ACHN quality goals;
d. Engagement as appropriate in the ACHN's Multidisciplinary Care Team and the development of an individualized and comprehensive Care Plan;
e. Certification requirements will be monitored on a monthly basis. ACHNs will report monthly to the Agency a list of PCP groups who are meeting certification requirements. If the ACHN indicates a PCP group is decertified due to failure to meet the certification requirements, then the Agency will confirm with the ACHN as well as the PCP group before allowing the PCP group to receive the ACHN certification rates.

5. Higher Levels of Service Defined by Engagement of ACHN Certified Maternity Care Providers (MCPs) with the ACHN Program:

a. MCPs, which include OB/GYNs, Nurse Midwives, and other physicians, a provide a higher level of service by engaging with an ACHN as described below:
   i. Providing data to the ACHN;
   ii. Engagement in the development of the Recipient's care plan; and
   iii. Engagement in the MCP selection and referral process.
b. Certification requirements will be monitored on a monthly basis. ACHNs will report monthly to the Agency a list of MCPs who they have contracted and engaging with to provide maternity services. MCPs who fail to meet certification requirements will no longer be referred to by the ACHN or will be able to provide maternity services to the ACHN population.

ACHN Certified Provider Rates

I. Rates for ACHN Certified PCPs:

ACHN Certified PCPs will receive higher rates for certain E&M billing codes (99202-99205, 99211-99215, 99242-99245) that are considered reimbursable by Alabama Medicaid. The ACHN Certified Rate fee schedule is effective October 1, 2024. All rates are published on the Agency's website at www.medicaid.alabama.gov.

To view the ACGN Certified Rates, visit www.medicaid.alabama.gov

a. click Providers tab
b. click fee schedules
c. click Physician Primary Care "ACHN Certified Rates"

The following provider groups are not eligible to receive the ACHN Certified Rates:

a. Federally Qualified Health Centers (FQHCs)
b. Rural Health Centers (RHCs)
c. OB/GYNs and Nurse Midwives
d. Nursing Facilities

IV. **Rates for ACHN Certified MCPs:**

a. ACHN Certified MCPs will receive an enhanced payment for:
   i. an initial prenatal visit in the first trimester and/or
   ii. post-partum visits.

V. **ACHN Certified Provider Performance Payments**

Performance Payments for ACHN Certified PCP Groups:

A performance payment pool will be established in the amount of $20 million annually to fund three (3) performance payments for ACHN Certified PCP groups. The performance payments' pool is allotted as follows: 50% for quality, 45% for cost effectiveness, and 5% for PCMH Recognition.

a. Quality Performance Payments
   a. Eligibility: All ACHN Certified PCP groups will be eligible for a performance payment if the PCP group meets the requirements described below.
   b. Methodology:
      i. ACHN Certified PCP groups that achieve annual performance benchmarks determined by the Agency are eligible to receive performance payments.
      ii. Benchmarks will be posted at www.medicaid.alabama.gov by September 2024 and will be updated annually at least 30 days prior to the contract period.
      iii. The quality benchmarks will be posted to: www.medicaid.alabama.gov Click the ACHN tab/Provider.
      iv. The amount available for the quarterly quality payment will be one-quarter (1/4) of the annual amount described above.
      v. The first payment will be made in October 2024. Subsequent payments will be made on a quarterly basis.
      vi. Level One Quality Performance Payment for the period between October 1, 2024 and March 31, 2026:
         1. The Agency will make quarterly payments in the first month of the quarter based on provider reporting of necessary data and other activities including provider engagement in the ACHN and their review and response to quality data provided by the Agency, implementing any policies and processes to improve the efficiency of their practices, and engaging with the ACHNs in preparation to be paid based on performance-based quality payments. Providers will also be readjusting their practice guidelines to manage attributed patient populations rather than Agency assigned panels.
         2. Payments made in this period are based on the engagement by the PCP group and not for the achievement of quality measurements.
         3. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.
      vii. Level Two Quality Performance Payment for the period of April 1, 2026 and beyond:
         1. The Agency's quarterly payments beginning with the April 2026 payment will be based on actual quality measure performance calculated for the services rendered for the previous 12 months with a 9-month time lag on a rolling basis. For example, the quarterly payments made during April 2026, will be based on the actual quality measure performance calculated for the period between July 1, 2024, and June 30, 2025. Similarly, the quality measure payments made during July 2026, will be based on the quality measure performance calculated for the period between October 1, 2024, and September 30, 2025.

3. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

c. Cost Effectiveness Performance Payments

a. Eligibility: All ACHN Certified PCP groups will be eligible for a performance payment if the PCP group meets or exceeds the cost effectiveness criteria established by the Agency.

b. Methodology:

i. ACHN Certified PCP groups that achieve annual performance benchmarks determined by the Agency are eligible to receive performance payments.

ii. Benchmarks will be posted at www.medicaid.alabama.gov by September 1, 2019 and will be updated annually at least 30 days prior to the contract period.

iii. The cost effectiveness performance payment criteria will be posted to: www.medicaid.alabama.gov
Click the ACHN tab/Provider

iv. The amount available for the quarterly cost effectiveness payment will be one-quarter (1/4) of the annual amount described above.

v. The first payment will be made in October 2019. Subsequent payments will be made on a quarterly basis.

vi. Level One Cost Effectiveness Payment for the period between October 1, 2019 and December 31, 2020:

1. The Agency will make quarterly payments in the first month of the quarter for review and response to cost effectiveness data provided by the Agency, implementing any policies and processes to improve the efficiency of their practices, and engaging with the ACHNs in preparation to be paid based on performance-based cost effectiveness payments. Providers will also be readjusting their practice guidelines to manage attributed patient populations rather than Agency assigned panels.

2. Payments made in this period are based on the engagement by the PCP group and not for the achievement of cost effectiveness measurements.

3. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

vii. Level Two Cost Effectiveness Performance Payment for the period of January 1, 2021 and beyond:

1. The Agency's quarterly payments beginning with the January 2021 payment will be based on actual cost effectiveness performance.

2. The cost effectiveness performance calculation compares a 12-month per member per month (PMPM) to a risk-adjusted expected PMPM based on the costs of similar PCP groups that treat Medicaid recipients. Groups will be ranked by an efficiency score that is derived from actual PMPM versus the expected PMPM. Performance payment will be made for PCP groups that meets a cost effectiveness score of less than 1.0. This calculation will occur as soon as the previous calendar year's performance has been calculated (anticipated date three months after the start of the second contract year). For example, the quarterly payments made in January 2021, April 2021, July 2021 and October 2021 will be based on the actual cost effectiveness calculated for the period between October 1, 2019 and September 30, 2020 providing three months of claims payment run-out.

3. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

d. Patient Centered Medical Home (PCMH) Performance Payments

The purpose of the PCMH Recognition performance payment is to incentivize providers to attain PCMH Recognition thereby ensuring Medicaid Recipients are receiving care through a nationally recognized medical home model.

a. Eligibility: All ACHN Certified PCP groups who receive PCMH recognition as described below.

b. Methodology:

i. PCMH Recognition information may be obtained at: www.medicaid.alabama.gov Click the ACHN tab/Provider

ii. The PCP group can obtain PCMH Recognition or certification through a nationally recognized entity such as National Committee for Quality Assurance (NCQA). Details from NCQA can be found at https://www.ncqa.org/programs/helath-care-providers-practices/patient-centered-medical-home-pcmh.

iii. The amount available for the quarterly PCMH Recognition payment will be one-quarter (1/4) of the annual amount described above.

iv. The first payment will be made in October 2019. Subsequent payments will be made on a quarterly basis.

v. Level One PCMH Performance Payment for the period between October 1, 2019 and September 30, 2020:

1. The Agency will make quarterly payments in the first month of the quarter for PCMH Recognition performance payments.

2. Payments made in this period are for PCP groups that have already obtained the Recognition or certification and PCP groups that are progressing toward attainment of Recognition or certification. To be eligible for the PCMH Recognition performance payment, PCP groups must attest to the status of their attainment of PCMH Recognition or to their progress towards attainment.

3. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

vi. Level Two PCMH Performance Payment for the period October 1, 2020 and beyond

a. Payments made in this period are for PCP groups that attest they have obtained the Recognition or certification. The Agency will review the PCP groups attestation on an annual basis on the last business day of the month prior to the first quarterly payment for the ensuing year. For example, the quarterly payments made in October 2020, January 2021, April 2021, and July 2021 will be based on the PCP groups attestation of their achievement of Recognition or certification as of the last business day in September 2020.

b. The amount of the performance payment distributed to each PCP group will be based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

c. If a PCP group does not meet PCMH Recognition and does not show adequate progress toward meeting recognition, the Agency will not pay the PCMH performance payment.

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.

4. Prescribed Drugs

Medicaid pays for covered outpatient legend and non-legend, brand and generic drugs prescribed by individuals 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.

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.

A. Notwithstanding specific reimbursement described in this section, payment for covered outpatient drugs (both brand and generic) dispensed by a:

1. Retail community pharmacy
2. Specialty pharmacy
3. Long-term care or institutional pharmacy (when not included as an inpatient stay)
4. 340B eligible entities (including 340B contract pharmacies) not listed on the U.S. Department of Health and Human Services Health Resources & Service Administration (HRSA) 340B Drug Pricing Program Database
5. Indian Health Service, Tribal and Urban Indian pharmacy

Shall not exceed the lowest of:

a. The Alabama Average Acquisition Cost (AAC) of the drug; when no AAC is available, the Wholesale Acquisition Cost (WAC) -4% for brand drugs and WAC + 0% for generic drugs, plus a reasonable professional dispensing fee of $10.64,

b. The Federal Upper Limit (FUL), plus a professional dispensing fee of $10.64, or

c. The provider's Usual and Customary (U&C) charge to the general public regardless of program fees.

B. Payment for blood clotting factor products will be the Average Sales Price (ASP) + 6% plus a professional dispensing fee of $10.64.

C. For eligible 340B entities listed on the U.S. Department of Health and Human Services Health Resources & Service Administration (HRSA) 340B Drug Pricing Program Database, payment shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus a professional dispensing fee of $10.64.

D. For facilities purchasing drugs through the Federal Supply Schedule (FSS), payment shall not exceed the entity's actual acquisition cost for the drug, plus a professional dispensing fee of $10.64.

E. For facilities purchasing drugs at Nominal Price, payment shall not exceed the entity's actual acquisition cost for the drug, plus a professional dispensing fee of $10.64.

F. Physician Administered Drugs (PADs) are reimbursed at a rate of ASP + 6%. For PADs that do not have a published ASP, the reimbursement is calculated based on published compendia pricing such as Wholesale Acquisition Cost (WAC). For PADs administered by 340B entities, payment shall not exceed the entity's actual acquisition cost for the drug.

G. Investigational drugs not approved by the FDA are not covered.

H. Medication Assisted Treatment (MAT) drugs for Opioid Use Disorder (OUD) are reimbursed as described above in Sections 4. A, C, D, E, and F.

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 IEPSs 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: 05/01/18

For DME items described in section 1861(n) of the Social Security Act, the pricing methodology is equal to the Medicare rate, and will be updated on an annual basis based on the January Medicare published rate. The agency's fee schedule rate is in effect for services provided on or after May 1, 2018. 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: 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.

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 date 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: 01/01/2023

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

Ground Emergency Medical Transport Services Reimbursement Add-On Payment
Effective Date: First full quarter after SPA approval

Effective with the first full quarter after receipt of CMS approval:

This program will provide enhancement payments to eligible ground emergency medical transport (GEMT) providers by implementing an add-on reimbursement fee to the base rates for eligible emergency medical transportation services. The reimbursement rate add-on will cover GEMT services and will be applied in lump sum quarterly payments to eligible Healthcare Common Procedure Coding System (HCPCS) emergency transport codes. The base rates for GEMT will not change with this amendment to the Alabama Medicaid's State Plan.

"Emergency medical transportation" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable federal, state and local statutes, ordinances, and regulations.

11. Ambulance Services (continued)

Effective 01/01/2023 (as defined 42 CFR § 410.40(b))

A uniform add-on rate per emergency transport will be determined quarterly and will not exceed one hundred percent (100%) of the difference between Medicaid payments otherwise made to each GEMT provider for GEMT services (base rates) and the amount providers would have received from commercial insurers for those services. Commercial rate data will be reported by surveyed providers and used to determine the statewide average commercial rates for each GEMT service. The statewide average commercial rates will be multiplied by the volume of Medicaid paid GEMT services for the previous quarter, to calculate the quarterly ambulance add-on payments total.

The quarterly ambulance add-on payments will not exceed the quarterly funding available. Add-on payments for each GEMT provider will be calculated for each quarter by multiplying the uniform add-on rate by the provider's volume of Medicaid transports billed with HCPCS codes A0429 BLS Emergency, A0427 ALS Emergency (Level 1), A0433 ALS Emergency (Level 2), A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport, and paid during the preceding quarter as determined through the Medicaid Management Information System. An evaluation of a patient by a GEMT provider is not eligible for an add-on payment when a transport is not provided.

GEMT providers not subject to licensure within the State of Alabama will not receive the add-on rate payment. The add-on rate payment does not apply to Medicare crossover transports.

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: 10/01/2024

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 b 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, 2025, 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.

13. Outpatient Hospital Services (continued)

(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, 2025, 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, 2025, 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, 2025, 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.

Outpatient Medicaid Base Payments:

For State fiscal years 2014 through 2021, 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.

Effective October 1, 2018, Long Acting Reversible Contraceptives (LARCs) will be reimbursed separately from the inpatient daily per diem rate when the LARC is provided as part of the inpatient obstetrical delivery or in the outpatient setting immediately after discharge. A separate outpatient claim may be submitted by the hospital for reimbursement under the appropriate HCPCS code when the LARC is provided in the inpatient setting immediately after delivery.

Effective October 1, 2021, Medicaid shall pay each in-state hospital a base amount from approved rates based on procedure codes as published on the Alabama Medicaid Agency website at https://medicaid.alabama.gov.

13. Outpatient Hospital Services (continued)

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 at www.medicaid.alabama.gov. 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.

b. Upper Payment Limit

For the period from October 1, 2018, through September 30, 2025, 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 paragraph 8 on page 8.3.b below, shall receive outpatient hospital access payments each state fiscal year. The outpatient hospital access payment shall be calculated as follows:

(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.

(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 excluding line 60.
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 excluding line 60.
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 excluding line 60.
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 will be obtained from the Alabama Medicaid MMIS system for claims incurred for services for each hospital's cost reporting period which meet the definition of a paid claim which would be covered during SFY 2025. 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). Medicaid utilization impacted by the COVID-19 public health emergency will be adjusted to reflect estimated utilization levels in the rate year prior to the COVID-19 public health emergency.

(4.) Total Medicaid outpatient charges in Step (3) on page 8.2 are multiplied by the cost to charge ratio calculated in Step (2) on page 8.2 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. 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 (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics- Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData) and a separate utilization increase based on change in paid ICN claim counts a linear regression completed for the previous five State Fiscal Years, excluding State Fiscal Years 2020,2021, and 2022, 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.

(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 (1) on page 8.2 by total charges for the hospital from the cost reports outlined in paragraph (1) on page 8.2.

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 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) on page 8.2 was obtained from the MMIS and includes the utilization adjustment described in Step (3) 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) on page 8.3 and the cost report factors in paragraph (4) on page 8.3 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) on page 8.3 to determine the Medicaid payments for the rate year and the preceding rate year.

13. Outpatient Hospital Services (continued)

(6.) The difference between Medicare cost of Medicaid services determined in Step (5) on page 8.3 and the Medicaid payments in Step (6) on page 8.3.a will be the Upper Payment Limit Gap for each hospital type.

(7.) Privately owned acute care hospitals, that meet the criteria in (a) and (b) below, may 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 (9) 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.

The enhancement payment under this section for the fiscal year ending September 30, 2025 is zero.

(8.) Each hospital, excluding private free-standing psychiatric hospitals, may receive outpatient access payments. Additionally, qualified hospitals under paragraph (8) 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 (7).

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.

(9.) Access payments are paid quarterly.

15. Case Management Services

Effective Date: 2/1/2012

(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 7 (Adult Protective Service Individuals) reimbursement will be as follows:

(a) Reimbursement interim rates will be established based on cost as determined by the quarterly Social Services Work Sampling Study. Interim 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 interim rate formulation, and identifies that at least one of the targeted case management core services listed above in B. 1, 2, 3, or 4 has been provided.

Sampling observations are developed using employee position numbers and basic statistical principles. The statistical principle used is random sampling with replacement where each position number has an equal chance of being selected for each observation as described in the federally approved Cost Allocation Plan.

(b) Governmental Providers for target group 4 (Foster Children) and target group 7 (Adult Protective Service Individuals) will submit an annual cost report not later than 90 days after the close of the following fiscal year. This report will indicate the costs associated with providing the service and also statistical data indicating the units of service, as described in (3) below, provided during the fiscal year. Costs will be included based on the applicable DHR cost allocation plan approved by CMS.

(c) Cost reports will be reviewed for reasonableness and an average cost per encounter will be computed. The average cost per encounter will be used as the interim reimbursement rate for the succeeding year.

(d) If the cost report indicates any underpayment or overpayment during the reporting year, a lump sum adjustment will be made.

(e) A maximum of one unit of case management services will be reimbursed per month for each eligible recipient receiving case management services as defined in (3) below.

(3) The case management unit of service (encounter) consists of providing any of the targeted case management core 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 services. This array of services is provided on an on-going basis during each month. One unit of service (encounter) consists of all contacts during the month. All contacts must be documented in the client's record for the coordination or linkage of services for a specific identified recipient.

(4) The monthly encounter payment for case management services of target group 4 (Foster Children) is 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. If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's recipient ID number **must** be used for billing purposes. However, if a specific child is identified as the primary recipient of treatment, then that child's recipient ID number **must** be used for billing purposes.

(5) Payment for case management services of target group 7 (Adult Protective Service Individuals) is limited to one person per family unit. However, when adult protective services are needed by other members of the family unit or when encounters are necessary by multiple providers, those services are provided as often as necessary to achieve the objectives of the case plan. These services may include investigation and case management services and are provided pursuant to statutory authority to achieve the degree of protection necessary and to assure the effectiveness of the services.

(6) For target group 1 (Mentally Ill Adults), target group 2 (Mentally Retarded Adults), target group 3 (Disabled Children), target group 5 (Pregnant Women), target group 6 (AIDS/HIV), target group 8 (Technology Assisted Waiver for Adults), and target group 9 (Substance Use Disorders) a unit of service is reimbursed in increments of five minutes. 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 Targeted Case Management. The Agency's rates were set as of November 1, 2018 and are effective for services provided on or after that date. All rates, including current and prior rates, are published and maintained on the Agency's website. The fee schedule is published at http://www.medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx

(7) Reimbursement for services provided by Governmental Providers for target group 4 (Foster Children) and target group 7 (Adult Protective Service Individuals) will be based on actual costs and meet all the requirements of 45 CFR §75 Uniform Administration Requirements, Cost Principles, and Audit Requirements for Health and Human Services (HHS) Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement.

(8) The monthly encounter rate for case management services of target group 10 (High Intensity Care Coordination) is limited to one recipient, per month. The monthly encounter rates were derived from an analysis of caseloads and staffing configurations, productivity, staffing costs and fee-for-service utilization. Staffing costs include salaries and wages, fringe benefits and operating and support costs. These staffing costs were based on existing costs of community mental health center staff and/or 310 Board staff that would meet the qualifications to perform Intensive Care Coordination.

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.

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.

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

Alabama Medicaid uses a Prospective Payment System (PPS) for FQHCs as required by S.S.A. §1902(a)(15) [42 U.S.C. § 1396a (a)(15)] and S.S.A. §1902(bb) [42 U.S.C. §1396a(bb)]. The PPS for FQHCs was implemented and took effect on January 1, 2001.

A. Prospective Payment System (PPS) rates

The baseline Prospective Payment System (PPS) for each FQHC (including "FQHC look alike clinics") in FY 2002 was developed by weighing the FQHC's provider specific reasonable costs for Fiscal Years 1999 and 2000 by the number of Medicaid encounters provided in each year. The FQHC is entitled to the previous year's PPS, increased by 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.

Prospective Payment System (PPS) Reimbursement for New Facilities

The rate established for a new FQHC shall be equal to 100% of the reasonable cost used in calculating the rates of like FQHCs located in the same or an adjacent area during the same fiscal year. The costs that must be considered in calculating the payment rate are those reasonable costs used in calculating the rates for neighboring clinics with similar caseloads.

Change in Scope of Services

The PPS rate for a FQHC shall be adjusted to take into account a change (either increase or decrease) in the scope of services furnished by the FQHC. A change in scope of services occurs if the FQHC has added or dropped any service that meets the definition of FQHC services as provided in section 1905(a)(2)(B) and (C) of the Social Security Act or if the service is included as a covered Medicaid service in the State Plan. A change in the scope of services is defined as a change in the type, intensity, duration, and/or amount of services provided during a FQHC visit. A change in the cost of a service is not considered in and of itself a change in the scope of services.

B. **Bonus Payment**

Beginning October 1,-2024, FQHCs that are Alabama Coordinated Health Network (ACHN) Certified are eligible to receive a bonus payment in addition to the PPS rate, but only if they meet the ACHN bonus payment criteria.

ACHN Certified Maternity Care Provider (MCP) Enhanced Payment
ACHN Certified MCPs will receive an enhanced payment for:

i. an initial prenatal visit in the first trimester and/or
ii. post-partum visits.

ACHN Certified Provider Performance Payments
Performance Payments for ACHN Certified Primary Care Provider (PCP) Groups:
A performance payment pool will be established in the amount of $20 million annually to fund three (3) performance payments for ACHN Certified PCP groups. The performance payments' pool is allotted as follows: 50% for quality, 45% for cost effectiveness, and 5% for PCMH Recognition.

a. Quality Performance Payments
   a. Eligibility: All ACHN Certified PCP groups will be eligible for a performance payment if the PCP group meets the requirements described below.

   b. Methodology:
      i. ACHN Certified PCP groups that achieve annual performance benchmarks determined by the Agency are eligible to receive performance payments.
      ii. Benchmarks will be posted at www.medicaid.alabama.gov by September 2024 and will be updated annually at least 30 days prior to the contract period.
      iii. The quality benchmarks will be posted to: www.medicaid.alabama.gov
           Click the ACHN tab/Provider.
      iv. The amount available for the quarterly quality payment will be one-quarter (1/4) of the annual amount described above.
      v. The first payment will be made in October 2024. Subsequent payments will be made on a quarterly basis.
      vi. Level One Quality Performance Payment for the period between October 1, 2024 and March 31, 2026:
          1. The Agency will make quarterly payments in the first month of the quarter based on provider reporting of necessary data and other activities including provider engagement in the ACHN and their review and response to quality data provided by the Agency, implementing any policies and processes to improve the efficiency of their practices, and engaging with the ACHNs in preparation to be paid based on performance-based quality payments. Providers will also be readjusting their practice guidelines to manage attributed patient populations rather than Agency assigned panels.

2. Payments made in this period are based on the engagement by the PCP group and not for the achievement of quality measurements.
3. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

vii. Level Two Quality Performance Payment for the period of April 2026 and beyond:
   1. The Agency's quarterly payments beginning with the April 2026 payment will be based on actual quality measure performance calculated for the services rendered for the previous 12 months with a 9-month time lag on a rolling basis. For example, the quarterly payments made during April 2026, will be based on the actual quality measure performance calculated for the period between July 1, 2024, and June 30, 2025. Similarly, the quality measure payments made during July 2026, will be based on the quality measure performance calculated for the period between October 1, 2024, and September 30, 2025.
   2. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

b. Cost Effectiveness Performance Payments

a. Eligibility: All ACHN Certified PCP groups will be eligible for a performance payment if the PCP group meets or exceeds the cost effectiveness criteria established by the Agency.

b. Methodology:
   i. ACHN Certified PCP groups that achieve annual performance benchmarks determined by the Agency are eligible to receive performance payments.
   ii. Benchmarks will be posted at www.medicaid.alabama.gov by September 1, 2019 and will be updated annually at least 30 days prior to the contract period.
   iii. The cost effectiveness performance payment criteria will be posted to: www.medicaid.alabama.gov
   Click the ACHN tab/Provider
   iv. The amount available for the quarterly cost effectiveness payment will be one-quarter (1/4) of the annual amount described above.
   v. The first payment will be made in October 2019. Subsequent payments will be made on a quarterly basis.

vi. Level One Cost Effectiveness Performance Payment for the period between October 1, 2019 and December 31, 2020:

1. The Agency will make quarterly payments in the first month of the quarter for review and response to cost effectiveness data provided by the Agency, implementing any policies and processes to improve the efficiency of their practices, and engaging with the ACHNs in preparation to be paid based on performance-based cost effectiveness payments. Providers will also be readjusting their practice guidelines to manage attributed patient populations rather than Agency assigned panels.
2. Payments made in this period are based on the engagement by the PCP group and not for the achievement of cost effectiveness measurements.
3. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

vii. Level Two Cost Effectiveness Performance Payment for the period of January 1, 2021 and beyond:

4. The Agency's quarterly payments beginning with the January 2021 payment will be based on actual cost effectiveness performance.
5. The cost effectiveness performance calculation compares a 12-month per member per month (PMPM) to a risk-adjusted expected PMPM based on the costs of similar PCP groups that treat Medicaid recipients. Groups will be ranked by an efficiency score that is derived from actual PMPM versus the expected PMPM. Performance payment will be made for PCP groups that meet a cost effectiveness score of less than 1.0.
6. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

c. Patient Centered Medical Home (PCMH) Performance Payments

The purpose of the PCMH Recognition performance payment is to incentivize providers to attain PCMH Recognition thereby ensuring Medicaid Recipients are receiving care through a nationally recognized medical home model.

1. Eligibility: All ACHN Certified PCP groups who receive PCMH recognition as described below.

2. Methodology:
   i. PCMH Recognition information may be obtained at: www.medicaid.alabama.gov
   Click the ACHN tab/Provider
   ii. The PCP group can obtain PCMH Recognition or certification through a nationally recognized entity such as National Committee for Quality Assurance (NCQA). Details from NCQA can be found at https://www.ncqa.org/programs/helath-care-providers-practices/patient-centered-medical-home-pcmh.
   iii . The amount available for the quarterly PCMH Recognition payment will be one-quarter (1/4) of the annual amount described above.
   iv. The first payment will be made in October 2019. Subsequent payments will be made on a quarterly basis.
   v. Level One PCMH Performance Payment for the period between
   October 1, 2019 and September 30, 2020:
      a. The Agency will make quarterly payments in the first month of the quarter for PCMH Recognition performance payments.

      b. Payments made in this period are for PCP groups that have already obtained the Recognition or certification and PCP groups that are progressing toward attainment of Recognition or certification. To be eligible for the PCMH Recognition performance payment, PCP groups must attest to the status of their attainment of PCMH Recognition or to their progress towards attainment.

      c. Payments will be distributed to each PCP group based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

vii. Level Two PCMH Performance Payment for the period October 1, 2020 and beyond

a. Payments made in this period are for PCP groups that attest they have obtained the Recognition or certification. The Agency will review the PCP groups attestation on an annual basis on the last business day of the month prior to the first quarterly payment for the ensuing year. For example, the quarterly payments made in October 2020, January 2021, April 2021, and July 2021 will be based on the PCP groups attestation of their achievement of Recognition or certification as of the last business day in September 2020.

b. The amount of the performance payment distributed to each PCP group will be based on the number of Medicaid members attributed to the PCP group for the prior quarterly period.

c. If a PCP group does not meet PCMH Recognition and does not show adequate progress toward meeting recognition, the Agency will not pay the PCMH performance payment.

Effective : 10/01/2022

21. Rehabilitative Services

A. A statewide maximum payment will be calculated for each service designated by a procedure code recognized by the Alabama Medicaid Agency as a covered service.

The Medicaid reimbursement for each service provided by a rehabilitative services provider shall be based on the following criteria in accordance with the methodology described below:

(1) For procedure codes with an assigned Medicare rate (i.e. CPT codes), the proposed rate will be the current published Medicare Physician Fee Schedule Rate for Alabama.

(2) For procedure codes without an assigned Medicare Rate on the Physician Fee Schedule (i.e. HCPCS) codes, the reimbursement will be 'By Report'. 'By Report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement (total allowed charge) for services included in the Physician Fee Schedule by the previous state fiscal years total Medicaid billings.
a. Percentage = Total 'Allowed Amount' / Total 'Billed Amount'
b. Average Billed Amount = Total 'Billed Amount' / Total 'Allowed Quantity'
c. Proposed Rate = Percentage times Average Billed Amount

(3) For procedure codes with no utilization one of the three methods below will be used.
a. Current rate that the Rehabilitative Services State Agencies utilizes.
b. Current rate from another state for same service.
c. For those services that need rate different from current Alabama or other state rate a financial cost model will be used to calculate rate.

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 Rehabilitative Services. The Agency's fee schedule rates were set as of October 1, 2018 and are effective for services provided on or after that date.
All rates are published and maintained on the Agency's website at www.medicaid.alabama.gov. For the most recent Rehabilitative Service Fee Schedule click on the Providers tab, select Fee Schedules, check "I Accept" on the User Agreement, then click the Providers tab, Fee Schedules, and Rehabilitative Option Fee Schedule.

(4) Medication Assisted Treatment (MAT) drugs for Opioid Use Disorder (OUD) as a part of the service for the MAT code are reimbursed as described above in Section (2).

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.

B. Bundle-specific rate setting
Bundled payment rates are added to the Alabama fee schedule according to the methodology described at A. above.

The state will regularly review utilization of services to ensure beneficiaries receive the types, quantity and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the bundle. Room and board or other unallowable facility costs are excluded from all rates.

Any provider delivering services through a bundle will be paid through that bundle's payment rate and cannot bill separately. Providers delivering separate services outside of the bundle may bill for those separate services in accordance with Alabama's Medicaid billing procedures.

At least one of the services included in the bundle must be provided within the service payment unit in order for providers to bill the bundled rate.

Medicaid providers must maintain records which fully demonstrate the extent, nature and medical necessity of services and items provided to Alabama Medicaid recipients.

Name of Service	Service Bundle Includes:	Rate Components Include:	Unit
Intensive Family Intervention by a Multi-Person Team	• Intake • Individual Counseling • Family Counseling • Medication Monitoring • Therapeutic Mentoring • Crisis Intervention • Psychoeducation • Mental Health Care Coordination • Basic Living Skills	• Direct Service Expenditures • Direct Staff Wages • Employee Benefit Costs • Direct Supervision • Program Support Costs • On-call differential for services that require 24-hour per day, 7-day a week on-call for crisis and response	Daily Per Diem

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

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.

Effective Date: 10/01/20
29. 1905(a)(29) Medication-Assisted Treatment (MAT)

Bundled prescribed drugs dispensed or administered as a part of the service for the MAT code shall be reimbursed using the same methodology as described in Attachment 4.19-B, section 21(2), for rehabilitative services.

Reimbursement for unbundled MAT prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for prescribed drugs in Attachment 4.19-B, page 3, sections 4(A),(C),(D),(E), and (F) for prescribed drugs that are dispensed or administered.

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)

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 MR Deductibles SP Coinsurance
Part B SP Deductibles SP Coinsurance

Other Medicaid Recipients: Part A MR Deductibles SP Coinsurance
Part B SP Deductibles SP Coinsurance

Dual Eligible (QMB Plus): Part A MR Deductibles SP Coinsurance
Part B SP Deductibles SP 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

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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/ Individual	QMB Medicare-QMB Individual
Part A Deductible	_ limited to State plan rates*	_ limited to State plan rates*	_ limited to State plan rates*
	X full amount	X full amount	X full amount
Part A Coinsurance	X limited to State plan rates*	X limited to State plan rates*	X limited to State plan rates*
	_ full amount	_ full amount	_ full amount
Part B Deductible	X limited to State plan rates*	X limited to State plan rates*	X limited to State plan rates*
	_ full amount	_ full amount	_ full amount
Part B Coinsurance	X limited to State plan rates*	X limited to State plan rates*	X limited to State plan rates*
	_full amount	_full amount	_ 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

Policy on Payment for Reserving Beds in an Inpatient Facility

Effective Date: **08/10/00**

Payments to facilities other than ICF/MR facilities will only be made for therapeutic visits not to exceed three days per visit and eight such visits per patient during any calendar year; limited to two visits per calendar quarter to home, relatives or friends. Payments to ICF/MR facilities for therapeutic visits are limited to 14 days per calendar month, not to exceed 14 consecutive days at any time.

Effective Date: **08/10/00**

Neither Medicaid patients, nor their families, nor their sponsor, may be charged for reservation of a bed when they are temporarily absent to a hospital for a period not to exceed four days. After the four-day reservation period, the patient, the family of the patient, or the sponsor of the patient is responsible for making arrangements with the nursing home for the reservation of the bed and any costs associated with reserving the bed for the patient. This policy does not apply to patients while they are on Medicare covered days.

Effective Date: **02/12/81**
The long term care facility must ensure that each therapeutically indicated visit by a patient is authorized and certified as necessary by a physician.

The complete therapeutic leave records will be retained at the long term care facility and will become an audit item for Alabama Medicaid Agency purposes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS/PROCEDURES FOR DETERMINING NURSING FACILITY REIMBURSEMENT

I. Introduction

Effective Date: 09/01/91

A. The following sections summarize the methods and procedures used by the Alabama Medicaid Agency (hereinafter "Agency") in determining proper reimbursement to nursing facilities. Under this plan, all facilities are considered the same with the exception of NF/IMD (Nursing Facility/Institution for Mental Disease) and NF/IDD (Nursing Facility/ Institution for the Developmentally Disabled). This summary does not apply to the classification of ICF/MR, which is an additional functional classification established by the Agency.

Effective Date 10/01/90

B. All reimbursement will be determined in compliance with generally accepted accounting principles, principles outlined in the State Plan, Medicare (Title XVIII) Retrospective Reasonable Cost Principles of Reimbursement, and principles and procedures promulgated by the Agency to provide reimbursement of provider costs which must be incurred by efficiently and economically operated nursing facilities. The Agency may, in the absence of applicable procedures, standards, and provisions within published Regulations, apply certain reasonability standards to expenses for which reimbursement is sought, to determine whether reimbursement should be made. The granting of variances to the Agency Reimbursement Principles will be discretionary with the Agency, based on the submission of substantiating documentation and convincing evidence by the provider that services can be provided in a more cost efficient manner if the variance is granted.

C. Providers/Administrators are expected to conduct their business in an efficient and cost-effective manner and to seek reimbursement only for those costs which must be incurred in the conduct of an economically and efficiently operated nursing facility.

D. The Agency will conduct desk reviews and on-site audits to insure that only allowable costs are allowed and reimbursed, and the Agency's previous failure to disallow costs shown in cost reports will not insure their continued allowance if those costs are identified as unallowable. In addition, attempts by a provider to include costs previously disallowed by the Agency may result in additional investigation by the Agency or investigation by the Alabama Attorney General.

E. The Agency recognizes the impact of inflation on all costs associated with doing business and has taken this into account in initiating the application of the Agency Inflation Index. The Alabama Medicaid Inflation Index shall be based upon the economic indicators as published by Data Resources, Inc. (DRI) for the Department of Health and Human Services. The indicators shall be the Market Basket Index of Operating Costs - Nursing Facility, which are published quarterly, whereas the Medicaid fiscal year for cost reporting and rate setting purposes ends on June 30. Therefore, the Medicaid Inflation Index for a rate period will be the DRI Index for the twelve-month period ending on the calendar quarter for which the index has been published or made available at October 1st of each year.

II. Cost Recording and Cost Reporting Procedures

A. All nursing facilities participating in the Alabama Medicaid Nursing Facility Program are required to report costs for the reporting period July 1 to June 30 of each year. The costs included are required to be detailed on the cost reports and must have been recorded by the facility on the basis of generally accepted accounting principles and in accordance with the accrual method of accounting.

B. Each nursing facility must submit its costs for the reporting period on the uniform cost report form provided by the Agency. Each complete cost report must be verified and must be received by the Alabama Medicaid Agency on or before September 15 for the report period ending the previous June 30. Should September 15 fall on a holiday or weekend, the complete, verified cost report must be received by the Alabama Medicaid Agency on the next working day. Failure to comply with the established deadline may result in the imposition of penalties against the facility. Nursing facilities ceasing their operation or terminating their participation in the program must submit a final cost report within seventy-five (75) days of cessation or termination.

C. All nursing facilities are required to maintain financial and statistical records for each cost reporting year, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least three (3) years following the date of submission of the cost report form to the Alabama Medicaid Agency. Records required by the Alabama Medicaid Agency to be maintained are specified in the Nursing Home Reimbursement Chapter of the Alabama Medicaid Agency Administrative Code. These records must be made available upon request to representatives of the Alabama Medicaid Agency or the United States Department of Health and Human Services.

D. The Alabama Medicaid Agency shall retain all uniform cost reports submitted in accordance with the requirements of the Alabama Medicaid Agency for a period of three (3) years following the date of submission of each report and will maintain those reports pursuant to recordkeeping and reporting requirements of the Department of Health and Human Services.

E. For hospital related facilities and domiciliary facilities, the step-down cost findings method must be applied to its allowable costs to ascertain the costs of the various services provided during the reporting period.

III. Allowable Costs

Effective Date: 09/01/91

A. Allowable Costs shall include all items of expense which providers must incur in the provision of routine services. Routine services means the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities.

1. Management and Administrative Costs - Specific, although not all inclusive, allowable management and administrative costs are set out in the Nursing Home Reimbursement Chapter (Chapter 22) of the Alabama Medicaid Agency Administrative Code. All nursing facilities will be arrayed by the number of beds in the facility, and those operating costs deemed allowable by the Alabama Medicaid Agency for each provider will be separated into two groups, 75 beds or less and 76 beds and over.

2. Interest Expenses - For this expense to be allowable, it must be reasonable, necessary, and incurred strictly to satisfy a financial need directly related to patient care. Additionally, interest paid to a related party will not be characterized as allowable.

3. Laundry Expenses - Allowable costs will be limited to the laundry costs which are ordinary and necessary to the operation of the nursing facility and will not include costs associated with the personal laundry of residents. The facilities will be reimbursed for personal laundry at a daily rate determined by the Agency. This rate is determined by Medicaid by an analysis of laundry expenses and income to determine a net revenue. The revenue is divided by total patient days.

4. Travel Expenses - Travel expenses will be allowed as long as those costs are calculated in strict compliance with Alabama Medicaid Agency standards as set out in the Agency's Administrative Code.

5. Property Costs - Those costs which are in accord with the standards established by the Alabama Medicaid Agency relating to property will be allowed. A Fair Rental System, as outlined in Chapter 22 of the Alabama Medicaid Agency Administrative Code, will be used to reimburse property costs.

6. Funding Qualified Retirement Plans - Cost of funding will be allowed for either a defined benefit plan or a defined contribution plan. Any other plan may be considered by the Alabama Medicaid Agency on an individual basis in light of the standards and principles set by the Alabama Medicaid Agency.

7. For nursing facilities which are part of hospitals, excessive allocations from the hospitals to the nursing home will be disregarded.

B. All allowable expenses will be examined to determine if costs are incurred from a related party in which case only the net costs to the related party will be allowed, and those net costs cannot exceed the fair market value of the goods or services.

C. All similar allowable costs will be categorized into one of four (4) groups, as follows:

1. Operating Costs - Administrative costs including medical records consultant.

2. Direct Patient Care Costs - Nursing services costs, raw foods, medical director, nursing consultant, pharmacy consultant, and dental consultant.

3. Indirect Patient Care Costs - Costs other than operating cost, direct patient care costs, and property costs such as: Plant operations, dietary (minus raw foods), laundry (less costs associated with patient personal laundry), activities, social services, housekeeping, beauty and barber (if provided free of charge by the facility), dietary consultant, and social services consultant.

4. Property Costs - Gross asset value, as defined in Chapter 22, of land, buildings, and equipment reduced by outstanding mortgage debt. Interest expense, property taxes, and property insurance are also included.

Effective Date: 10/01/90

D. Total costs as reported will be offset by certain income items or receipts of the facility, as more fully described within published Regulations.

Effective Date 10/01/93

E. Effective October 1, 1990, rates to nursing facilities took into account the costs of nursing facility's compliance with the requirements of §1919(b) (other than paragraph (3)(F) thereof), (C) and (d) of the Social Security Act.

1. For the period beginning October 1, 1990, nursing facilities were permitted to budget estimated costs of compliance with OBRA 87. Each facility submitted a budget for the estimated annual cost for each position to be filled because of OBRA 87 requirements. Funding would be made available to cover the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Additional health care staff was authorized as outlined below:

1 RN per 50 Residents for assessments
1 LPN per Facility for rehab nursing
1 Qualified Social Worker for facilities of 120 beds and larger
1 Activities person per 60 Residents

Change staffing ratios for nurse aides:

SHIFT	FROM	TO
7 - 3	1 - 10	1 - 6
3 - 11	1 - 15	1 - 10
11 - 7	1 - 25	1 - 20

Quarterly, beginning October 1, 1990, through April 1, 1991, each facility submitted a hiring form reporting the annual salary of actual staff, as authorized in approved budgets, hired that quarter. Such costs per day were added to the existing per diem rates outside the ceiling limitation. We estimated the average cost of those budgeted costs to be approximately $5.44 per day.

2. Effective September 1, 1991, a new reimbursement methodology was implemented to provide for maintaining the highest practicable physical, mental, and psychosocial well-being of each resident. Estimated OBRA 87 costs based on the above staffing requirement were added to the per diem rates and were considered in setting ceiling limitations.

3. Effective January 1, 1992, nursing home reform costs were included in establishing the per diem rates and were included in setting ceiling limitations. This was done by taking the reported nursing home reform expenses in the June 30, 1991, cost report and adding, as a budget figure, the difference between nursing home reform expenses in the cost report and the dollar amount authorized on the October 1, 1990, budget form. Effective with the June 30, 1992 cost reports, and continuing forward, the cost of nursing home reform will be included in with all nursing facility allowable costs.

Effective Date 10/01/90

IV. Audits and Rate Computation

A. Nursing facilities will be audited by members of the Audit Staff of the Alabama Medicaid Agency or outside auditors, to insure that reimbursement is made only for allowable costs, as detailed in Section B.

1. A desk review and analysis is made on data submitted on each uniform cost report. The analysis consists of a complete review of historical costs and an examination of costs for the reporting period as set out in the report. Subsequent to the desk review and analysis of all submitted cost reports, a payment rate is established for each facility. This rate is subject to adjustment resulting from an in-depth audit of that facility's records.

2. The Alabama Medicaid Agency will conduct analyses of the uniform cost reports by January 1 of each year for those reports covering the reporting period ending the previous June 30 to verify that a complete cost report has been filed by each facility and to verify that it has properly detailed the costs for which it is seeking reimbursement.

Effective Date 10/01/98

3. Each nursing facility will be audited as necessary by an in-depth, on-site audit. Unless a waiver is specifically granted by the Alabama Medicaid Agency, all records which substantiate the information reflected in the cost report(s) being audited are to be made available at the facility, and Alabama Medicaid Agency's audit staff is to be provided adequate facilities and privacy to conduct the audit.

4. Subsequent to an audit of a facility, a final report of audit will be forwarded to the facility and certain disallowances of costs as reported on the cost report may be necessitated by the findings of the audit staff, resulting in a change of the per diem reimbursement rate. It is also possible that an audit may obviate underpayments
by the Alabama Medicaid Agency to the provider, both situations resulting in the need to either recoup from or pay to the provider any over or underpayments due.

5. This settlement will be achieved in either event by a lump sum payment from the party underpaying (Alabama Medicaid Agency or being overpaid (the provider), and an adjustment in the per diem rate.

6. Prior to collection of any amount due the Alabama Medicaid Agency as a result of disallowances contained in the final report of audit, the facility will be given thirty (30) days to contest Alabama Medicaid Agency's findings and to request an informal conference to present its position. Subsequent to any informal conference, an administrator who feels the results of the informal conference are adverse to his facility may request a fair hearing in writing within fifteen (15) days of Alabama Medicaid Agency's mailing its determination on the issues presented at the informal conference. All fair hearings are conducted in accordance with Alabama Medicaid Agency regulations governing fair hearings. The Alabama Medicaid Agency will account for overpayments found in audits on the quarterly statement of expenditures no later than sixty (60) days after the overpayment was found.

7. Nursing Facilities will be reimbursed on a reasonable cost-related basis, and payments will be based on the lower of the facility's billing rate or maximum reimbursement rate or the facility's usual and customary charge to the general public for the same range of services minus applicable patient income.

Effective Date 01/16/2012

8. For reimbursement, all nursing facility providers will be grouped into three (3) functional categories: NF, NF/IMD, and NF/IDD. All similar allowable costs will be categorized into one of four (4) groups: operating costs, direct patient care cost, indirect patient care cost, and property cost. NF/IMD and NF/IDD facilities will be exempt from all ceilings.

(a) Operating Costs - The ceiling for operating costs will be at the median cost per patient day plus 5% for each of the two bed size groupings. Actual allowable reported cost per patient day up to the ceiling will be used to establish the rates.

The allowable management and administrative cost for each facility will be divided by reported patient days. All nursing facilities will be grouped by the number of beds in the facility and the operating costs for each facility will be separated into two bed size groupings, 75 beds or less and 76 beds and over. Each grouping will be arrayed by the cost per patient day. The median plus 5 percent will be determined for each grouping that will be the ceiling. This ceiling, or actual cost, whichever is less will be used for each provider's rate computation.

Ceilings are determined annually based upon allowable cost submitted in the Alabama Medicaid Nursing Home cost reports ending June 30th of each year.

(b) Direct Patient Care Cost - The ceiling for the direct patient care costs is the median cost per patient day plus 10%. Actual allowable reported cost per patient day plus 11% not to exceed the established ceiling plus 11% will be used to establish the rates.

Direct care costs, consisting of nursing services, raw foods, medical director, nursing consultant, pharmacy consultant and dental consultant for each facility will be divided by reported patient days. These costs per patient day will be arrayed and the ceiling for the direct patient care cost center will be the median cost per patient day plus 10 percent. The provider's actual allowable reported cost per patient day plus 11 percent not to exceed the established ceiling plus 11 percent whichever is less will be used for each provider's rate computation.

Ceilings are determined annually based upon allowable cost submitted in the Alabama Medicaid Nursing Home cost reports ending June 30th of each year.

(c) Indirect Patient Care Cost - The ceiling for indirect patient care cost is the median cost per patient day plus 10%. Actual allowable reported cost per patient day plus 50% of the difference between reported cost and the ceiling up to the ceiling amount will be used to established rates.

Costs for plant operations, dietary (minus raw foods), laundry (less costs associated with patient personal laundry), activities, social services, housekeeping, beauty and barber (if provided free of charge), dietary consultant, social services consultant, and other allowable costs,

will be divided by reported patients days. These costs per patient day will be arrayed and a median cost per patient day will be determined. The ceiling for indirect patient care costs is the median cost per patient day plus 10 percent. The providers actual allowable reported cost per patient day plus 50 percent of the difference between actual allowable cost and the established ceiling up to the ceiling amount, will be used for each provider's rate computation.

Ceilings are determined annually based upon allowable cost submitted in the Alabama Medicaid Nursing Home cost reports ending June 30th of each year.

(d) Property Cost - Property costs will be reimbursed under a fair rental system as set out in the Nursing Facility Reimbursement Chapter (Chapter 22) of the Alabama Medicaid Agency Administrative Code. Facilities categorized as NF/IMD will be reimbursed a usage allowance of 2% for building values and 6 2/3% for equipment instead of the fair rental.

Current Asset Values (CAV) for Nursing Homes are based upon historical data rebased annually using Marshall Swift Evaluation. Effective October 1, 2020, the CAV will be increased by 41.03% due to increased costs of Nursing Homes. Allowable interest expense, property taxes and property insurance are determined from the annual Alabama Medicaid Nursing Home cost report ending June 30th of each year or the latest available cost report.

(e) Reimbursement will be the sum of these cost groupings as adjusted under the provisions of Chapter 22 of the Alabama Medicaid Agency Administrative Code.

Allowable cost is determined based upon the annual Alabama Medicaid Nursing Home cost report ending June 30th of each year of the latest available cost report.

Effective Date: 10/01/90

9. The on-site audits conducted in accordance with generally accepted auditing standards will result in an audit report which will contain the auditor's opinion as to whether, in all material respects, the uniform cost report includes only expense items allowable under the Alabama State Plan, as detailed under Section III of this attachment, and that the expense items included are accurately determined, attributed, and are reasonable. These audit reports shall be kept by the Alabama Medicaid Agency for at least three (3) years following the date of submission of such reports, and will be maintained pursuant to the record keeping and reporting requirements of 42 CFR §431.16.

B. Alabama has determined that the payment rates resulting from the Alabama Medicaid Agency methods and standards are at least equal to the level at which the State calculates a facility can be economically and efficiently operated.

C. Payment rates to SNF's and ICF's are determined prospectively with an annual recalculation of applicable rates. Alabama does not, however, adjust the per diem reimbursement rates to a nursing home provider based on service deficiencies or quality of service.

V. Payment Assurances and Payment Limitations

A. The State will pay each provider of nursing care services, who furnishes services in accordance with the provisions of the State Plan, the amount determined for services furnished under said Plan.

B. State payments made pursuant to the State Plan for nursing facilities shall not exceed the general payment limits established by the United States Congress and implemented through Agency regulations, when such limits are established by the Secretary of Health and Human Services. These payments shall under no circumstances exceed the facility's customary charges to the general public for services.

C. It is a primary intent that payments made in accordance with the methods, provisions, and standards of the Alabama Medicaid Agency Nursing Facility Reimbursement chapter of the Agency's Administrative Code will serve to ensure the participation of a sufficient number of providers of services in the program so that medical care and services included in the State Plan are available to eligible persons at least to the extent that they are available to the general public.

D. The Alabama Medicaid Agency will pay nursing facilities a supplemental fee-for-service payment for care provided to ventilator-dependent residents who are eligible for Medicaid benefits.

The nursing facility and the ventilator-dependent/tracheostomy resident must meet specific requirements established by the Medicaid Agency.

The nursing facility must meet and comply with the following in order to be considered to receive the supplemental fee for ventilator-dependent/tracheostomy residents:

- Comply with all of the State and federal requirements governing nursing facilities, including physical and life safety requirements
- Ensure that an RN or LPN has primary responsibility for the unit
- Ensure that in-house respiratory services are provided by a licensed Respiratory Therapist 24 hours per day
- Provide a program of initial training and ongoing in-service training for direct care staff
- Ensure that physician visits are conducted in accordance with federal regulations for nursing facilities
- Not accept a ventilator-dependent and/or qualified tracheostomy resident if any of the following situations exist:
  - Termination of the NF's Medicaid certification is imminent; or
  - The NF is a Special Focus Facility, under review by CMS, or the State Survey Agency, or the Alabama Medicaid Agency.

must meet specific requirements established by the Medicaid Agency.

The nursing facility will be reimbursed the daily per diem rate determined for the nursing facility plus an additional daily payment for the ventilator-dependent/tracheostomy resident.

The supplemental fee-for-service payment will be $120.00 and indexed annually in accordance with the cost of living increases based upon the economic indicators as published by Data Resources, Inc. (DRI) for the Department of Health and Human Services.

E. Providers who participate in the program shall accept as payment in full, those amounts paid to them in accordance with the State Plan.

VI. Compliance with Provisions, Methods and Standards

In order to assure compliance with its regulations, the Alabama Medicaid Agency has established certain penalties which may be assessed at its discretion, the details of which are fully set out in the Agency Administrative Code.

VII. Miscellaneous

A. The Alabama Medicaid Agency will utilize appropriate methods of notifying the public concerning proposed, substantial changes in methods and/or standards, and prior to the implementation of any substantial change in methods and/or standards, the public will have an opportunity to review and comment on the proposed changes.

B. Detailed information regarding the reimbursement methodology and related matters appears in Chapter 22 of the Alabama Medicaid Agency Administrative Code.

C. The regulations of the Alabama Medicaid Agency are implemented under the provisions of the Administrative Procedures Act. Through this process, the agency must publish its intent to make any changes in the reimbursement methodology. Copies of the methodology and data used to establish per diem rates may be obtained by the public upon written request and payment of a reproducing fee.

Effective Date: 5/01/02

D. In order to provide services to Alabama Medicaid recipients when there is no Alabama nursing facility with a suitable bed available that meets the medical needs of the recipient, the Agency may contract with out-of-state facilities at the other states' Medicaid reimbursement rate. The Agency will only make a placement of an Alabama Medicaid recipient into an out-of-state facility if (1) no Alabama nursing facility bed is available that meets the medical needs of the recipient, (2) in-state alternatives for providing services have been exhausted, and (3) prior approval for placement into an out-of-state facility is sought through the Agency. If the Agency determines based upon the prior approval process to make a placement of the Alabama Medicaid recipient into an out-of-state nursing facility as described in 42 CFR 435.403(e) the recipient will remain an Alabama resident. Once an Alabama nursing facility bed meeting the medical needs of the recipient is available, the recipient must return to Alabama to remain eligible for Alabama Medicaid.

Alabama will contract with out-of-state nursing facilities on an as needed basis. Alabama will use the out-of-state facility's survey conducted by its survey and certification agency. No year-end Alabama Medicaid nursing facility cost report will be required from the contracting out-of-state facility nor will there be any requirement for Alabama conducted periodic audits.

Effective Date: 10/01/20

E. A Quality Incentive Add-on payment will be distributed to nursing homes annually.

Quality Incentive Component
For each measure, a provider is awarded points. The points are adjusted based on provider total Medicaid patient days and the resulting adjusted point value is used to determine a provider's portion of Quality Incentive funds.

Process Measures
For each process measure, each provider will be ranked and points will be awarded based on the percentage in which the provider scores in relation to the national average for the measure. For each rate period, the process measures will be calculated using the most recent four quarter average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of July 1 of the year in which the rate period begins.

1. Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine
2. Percentage of long-stay residents assessed and appropriately given the seasonal pneumococcal vaccine
3. Percentage of long-stay residents who received an antipsychotic medication

Outcome Measures
For each outcome measure, each provider will be ranked and points will be awarded based on the percentage in which the provider scores in relation to the national average for the measure. For each rate period, the outcome measures will be calculated using the most recent four quarter average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of July 1 of the year in which the rate period begins.

1. Percentage of long-stay residents who were physically restrained
2. Percentage of SNF residents with pressure ulcers that are new or worsened

The customer satisfaction process measure will be calculated as reported on the most recent Satisfaction Survey Summary Report as prepared by NRC Health. The survey measure will evaluate the combined Resident and Family response to the "Willingness to Recommend" survey element. For Year One of the Quality Incentive the Agency will only evaluate the response rate of the combined Resident and Family surveys. Starting with Year Two the points will be based on actual survey results.

Quality Incentive Add-Ons

1. To be eligible for the Quality Incentive a facility must:
   a. Accept Medicaid recipients;
   b. Participated and completed the most recent Satisfaction Survey by NRC Health; and
   c. Earned a minimum of four (4) points based on the below criteria.

2. Points are awarded to a provider for each quality measure using the following criteria:

Process Measures	0.75 points	1 point	2 points	3 points	Max Points Per Provider
Flu Vaccine	*10% year over year improvement	N/A	N/A	At or Above the National Average	3
Pneumonia Vaccine	*10% year over year improvement	N/A	N/A	At or Above the National Average	3
Antipsychotic	*10% year over year improvement	At or Above the National Average	20% Above the National Average	40% Above the National Average	3

Outcome Measures	0.75 points	1 point	2 points	3 points	Max Points Per Provider
Restraints	*10% year over year improvement	N/A	N/A	At or Above the National Average	3
Pressure Ulcers	*10% year over year improvement	At or Above the National Average	5% Above the National Average	10% Above the National Average	3
Customer Satisfaction – Recommendation**	N/A	Improve TopBox Excellent score by 5-points from previous year.	Exceed National Average for Top3Box Excellent, Very Good, Good Score	Exceed National Average for TopBox Excellent Score	3

**Year over Year improvement is calculated as the change from the year preceding the current year to the current year measurement. For Year One there will be no calculation for annual improvement as it will be considered the Baseline Year performance.*
***For Year One of the Quality Incentive the facility must achieve a combined response rate of thirty percent (30%) on the Resident and Family surveys. If the response rate is achieved the Facility will receive three points. If the response rate is not met, the facility will receive zero (0) points and would only be eligible for the Incentive if they achieve at least 4 points in the other catergories.*

3. Three Quarter points for year over year improvement are only awarded to providers who do not meet the criteria to earn 1-3 points within the measure.
4. Providers must have a quality score of at least the four (4) points to qualify for a quality incentive payment.
5. Participation in the Quality Incentive Add-On is voluntary and a facility has the option to opt out and not participate.
6. The weighted provider score for each qualifying provider is calculated by multiplying the provider quality points by the number of annualized Medicaid days as reported on the most recent June 30 cost report received by the Alabama Medicaid Agency. The payment per quality point is established by dividing the total quality budget by the sum of all weighted provider scores. The per diem quality incentive component is calculated by multiplying a provider's weighted quality score by the payment per quality point.

STATE ALABAMA

METHODS/PROCEDURES FOR DETERMINING REIMBURSEMENT RATES FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)

Effective Date: 10/12/88

I. Introduction

A. The following sections summarize the methods and procedures used by the Alabama Medicaid Agency (hereinafter "Agency") in determining proper reimbursement to providers operating long term care facilities functionally classified as Intermediate Care Facilities for the Mentally Retarded.

B. All reimbursement will be determined in compliance with generally accepted accounting principles, principles outlined in the State Plan, Medicare (Title XVIII) Retrospective Reasonable Cost Principles of Reimbursement, and principles and procedures promulgated by the Agency to provide reimbursement of provider costs which must be incurred by efficiently and economically operated ICF/MRs. The Agency may, in the absence of applicable procedures, standards, and provisions within published Regulations, apply certain reasonability standards to expenses for which reimbursement is sought, to determine whether reimbursement should be made. The granting of variances to the Agency Reimbursement Principles will be discretionary with the Agency, based on the submission of substantiating documentation and convincing evidence by the provider that services can be provided in a more cost efficient manner if the variance is granted.

C. Providers/Administrators are expected to conduct their business in an efficient and cost effective manner and to seek reimbursement only for those costs which must be incurred in the conduct of an economically and efficiently operated facility.

D. The Agency will conduct desk reviews and on-site audits to insure that only allowable costs are allowed and reimbursed, and the Agency's previous failure to disallow costs shown in cost reports will not insure their continued allowance if these costs are identified as unallowable. In addition, attempts by a provider to include costs previously disallowed by the Agency may result in additional investigation by the Agency or investigation by the Alabama Attorney General's Medicaid Fraud Control Unit.

E. The Agency recognizes the impact of inflation on all costs associated with doing business and has taken this into account in initiating the application of an inflation index. The inflation index shall be based upon the economic indicators as published by Data Resources, Inc. (DRI) for the Department of Health and Human Services. The indicators shall be the Market Basket Index of

Operating Costs - Skilled Nursing Facility, which are published quarterly, whereas the Medicaid fiscal year for ICF/MR for cost reporting purposes ends on September 30. Therefore, the inflation index for the rate period will be the DRI Index for the twelve-month period ending on the calendar quarter for which the index has been published or made available at October 1st of each year.

This factor shall be used to inflate allowable historical operating costs (excluding salaries and wages for State owned facilities). This factor shall not apply to depreciation, interest, lease payments, insurance, taxes or any other property costs. Salary increases shall be computed separately for state owned facilities. Property costs will be computed separately, and projections on these items will be allowed if they are not prohibited or limited by other provisions of this plan.

II. Cost Finding and Cost Reporting Procedures

A. All ICF/MR facilities are required to report costs for the twelve months ending September 30th of each year.

B. All ICF/MR facilities are required to detail their costs for the entire reporting year, or for the period of participation in the plan, if less than the full reporting year, for allowable costs under the Alabama Plan. These costs are recorded by the facility on the basis of generally accepted accounting principles and the accrual method of accounting. Cash basis accountability will be allowed only for those ICF/MR facilities operated by, or for, an agency of the Federal, State or county governments.

C. All ICF/MR facilities are required to report costs on the uniform cost report form provided by the State Agency. All uniform cost reports must be filed with the State Agency within sixty (60) days of the close of the cost reporting year, unless an extension is authorized, or adequate justification is provided. Failure to comply with the established deadline may result in the imposition of penalties against the facility.

D. All nursing facilities are required to maintain financial and statistical records for each cost reporting year, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least three years, plus the current year, following the date of submission of the cost report form to the State Agency. These records must be made available upon demand to representatives of the State Agency or the United States Department of Health and Human Services.

E. The State Agency shall retain all uniform cost reports submitted in accordance with paragraph "C" above for a period of three years, plus the current year, following the date of submission of such reports and will maintain those reports pursuant to the

record keeping and reporting requirements of the Department of Health and Human Services.

III. Allowable Costs

A. The following items of expense are allowable costs under the Plan:

1. All items of expense which providers must incur in meeting certification standards, to include costs involved in meeting the definition of intermediate care facility for the mentally retarded as contained in the Social Security Act or H&HS publications, costs to comply with the standards prescribed by the Secretary of Health and Human Services, costs to comply with the standards established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR §442.400 and costs to comply with any other requirements for licensing under State law. Some cost center limitations are detailed in Chapter 42 of the Alabama Medicaid Administrative Code.

2. Allowable costs include reasonable costs of providing quality care. Implicit in the intention that reasonable costs be paid is the expectation that the provider seeks to minimize its costs and that its costs do not exceed what a prudent and cost conscious buyer pays for a given item of service or product. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not allowable costs. Costs related to resident care include all necessary and proper costs involved in developing and maintaining the operation of resident care facilities and activities. Necessary and proper costs related to resident care are usually costs which are common and accepted occurrences of similar providers. They include such costs as property costs, resident care costs, maintenance costs, administrative costs, etc.

3. An allowance for return on equity capital for proprietary providers is also provided. This rate of return shall be equal to the average of the rate of the Federal Hospital Insurance Trust Fund for the twelve-month period ending September 30th of each cost reporting year.

Effective Date: 03/01/96

4. Depreciation will be an allowable cost for non-governmental providers. In lieu of depreciation for the use of buildings and improvements, State and local units of government will be compensated through use allowance. A use allowance for buildings and improvements may be computed at an annual rate not exceeding two percent of acquisition cost.

Major movable equipment for State owned and operated local units will be depreciated.

Effective Date: 10/01/92

5. Interest Expenses - For this expense to be allowable, it must be reasonable, necessary, and incurred strictly to satisfy a financial need directly related to patient care. Additionally, interest paid to a related party will not be characterized as allowable.

6. Bad debts of patients and charity and courtesy allowances shall not be included in allowable costs.

7. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable items purchased elsewhere. Providers shall identify such related organizations and costs in their cost reports.

8. A multiple-facility complex which has an ICF/MR and other components, such as a hospital, must establish separate cost entities to insure an equitable distribution of indirect costs to all cost centers. This allocation method must be approved by the Alabama Medicaid Agency and any excessive allocation to the ICF/MR facility will be disregarded.

B. Audits and Rate Computation

Description of State's Procedures for Audits - General: ICF/MR facilities will be audited by members of the audit staff of the Alabama Medicaid Agency or by an independent audit firm to ensure that reimbursement is being made only for allowable costs.

1. A desk review and analysis is made on data presented in the Uniform Cost Report. This analysis consists of a review of historical costs and an evaluation of budgeted changes. A payment rate is established based on this analysis and this payment rate is subject to modification, based on findings disclosed by a subsequent in-depth audit.

The standards, desk review, and on-site audits will be sufficient to ensure that only expense items allowable under the Alabama Plan are included in the facility's Uniform Cost Report and that the expense items included are accurately determined and attributed and are reasonable.

2. The State Agency will conduct analyses of the Uniform Cost reports by January 1st of each year of the reports submitted for the reporting year ending the previous September 30th to verify that the facility has complied with paragraphs (1) and (2) above in Section A.

3. When certain budgeted data presented in the cost report appears to be disproportionate to the historical costs or to prevailing conditions in other facilities, additional analysis or audit is performed before a rate is established.

4. An in-depth, on-site audit of each facility will be conducted as necessary. The audit standards set forth in Health Insurance Manual (HIM-18) will govern the audit procedures, along with the more specific guidelines established in the Alabama Medicaid Audit Guide for ICF/MRs. Financial records and other pertinent documents will be closely analyzed. These on-site audits will be conducted in accordance with generally accepted auditing standards and will be sufficiently comprehensive in scope to determine that only proper items of cost were included in the Uniform Cost Report and complies with paragraph (B)(1) above.

5. The on-site audits conducted in accordance with paragraph (B)(4) above shall produce an audit report, which shall meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the Uniform Cost Report includes only expense items allowable under the Alabama Plan, and that the expense items included are accurately determined and attributed, and are reasonable. These audit reports shall be kept by the State Agency for at least three years following the date of submission of such reports, and will be maintained pursuant to the record keeping and reporting requirements of the Department of Health and Human Services.

6. Subsequent to an audit of a facility, a Report of Audit will be forwarded to the facility. Certain disallowances of costs as reported on the cost report may be necessitated by the findings of the audit staff, resulting in a change of the per diem reimbursement rate. It is also possible that an audit may obviate underpayments by Medicaid to the provider, both situations resulting in the need to either recoup from or pay to the provider any over or underpayments due.

7. This settlement will be achieved in either event by a lump sum payment from the party underpaying (Alabama Medicaid

Agency) or being overpaid (the provider), and an adjustment in the per diem rate.

8. Prior to collection of any amount due the Alabama Medicaid Agency as a result of disallowances contained in the final report of audit, the facility will be given thirty (30) days to contest Medicaid's findings and to request an informal conference to present its position. Subsequent to any informal conference, an administrator who feels the results of the informal conference are adverse to his facility may request a fair hearing in writing within fifteen (15) days of Medicaid's mailing its determination on the issues presented at the informal conference. All fair hearings are conducted in accordance with Alabama Medicaid Agency rules governing fair hearings.

9. Payment rates to ICF/MRs are determined prospectively and are redetermined annually effective with rates established after the first cost reporting year.

Effective Date: 10/01/93

10. ICF/MRs will be reimbursed on a reasonable cost-related basis and payments will be based upon the lower of the facility's billing rate or maximum reimbursement rate or the facility's usual and customary charge to the general public for the same range of services minus applicable patient income. In the above statement, the billing rate is equal to the rate determined using the following methodology:

(a) Net reported costs (Schedule B, Column 5 of the cost report) shall be adjusted for cost recovery items, unallowable cost and excess administrative costs.

(b) Costs as adjusted in (a) above (less any property cost) Shall be separated into Salaries and other cost. The other cost will be multiplied by the Medicaid inflation index to calculate a budgeted increase in other expense. To determine a projected increase in salaries, the amount or % increase specified by the provider shall be used.

(c) Budgeted increases/decreases (rent, depreciation, interest, major repairs) shall be calculated using as a basis data supplied by the provider.

Effective Date: 03/01/96

(d) In lieu of depreciation for buildings and improvements, a use allowance shall be determined for governmental entities. Major movable equipment for governmental entities will be depreciated (see Appendix A).

Effective Date: 10/01/93

(e) The allowable equity capital will be multiplied by the percentage rate of return specified in Rule No.

560-X-42-.13 and the product will be the allowance for Return on Equity Capital. (This allowance applies to proprietary providers only.)

(f) The sum of the amounts as determined in (a) - (e) above shall be divided by total patient days as reported by the provider. The resulting average cost per day will be arrayed within each of the two functional groupings of facilities. The number of facilities in each grouping will be multiplied by 90% to determine the position of the facility that represents the 90th percentile. If the 90th percentile does not fall on a whole number, the Agency will round up or down to the nearest whole number. If the number falls on .0 to .49, we will round down. If the number falls on .50 or higher, we will round up. Counting from the bottom of the arrayment (upward) that facility's cost in each grouping will be the ceiling reimbursement rate for all costs of the homes within that functional class.

(g) The ICF/MR facilities are considered a separate class under the Alabama Long Term Care Program. Within this class are two groupings of facilities:

(1) Institutionally based, larger than fifteen (15) beds

(2) Institutionally based, with at least four (4), but no more than fifteen (15) beds

Within each of these facility groupings, the maximum reimbursement rate per day for a particular facility is the maximum reimbursement (as determined in (f) above) for the category in which the facility is assigned.

(h) Once the percentile ceilings have been established for a calendar year, they will be final and not normally subject to revision or adjustment during the year. Since the ceiling rates are based on information contained in the cost reports, it is to the benefit of each provider to insure that the provider's information is correct and accurate. If obvious errors are detected during the desk audit/review process, providers will be given an opportunity to submit corrected data.

(i) Finally, if a change in ownership or level of care or number of beds licensed has occurred, a facility may project the costs which are then divided by the projected total inpatient days.

(j) The monthly rate is computed by multiplying the per diem rate by 30.42 days. This rate is valid for patients in the facility for a full month. For partial month coverage, the per diem rate is multiplied times the number of days.

IV. Payment Rates Resulting from Methods and Standards

Alabama has determined that the payment rates resulting from these methods and standards are at least equal to the level which the State reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

V. Payment Assurances and Payment Limitations

A. The State will pay each provider of ICF/MR services, who furnishes the service in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan.

B. State payments made pursuant to the State Plan for ICF/MR facilities shall not exceed the general payment limits established by the United States Congress and implemented through Agency regulations, when such limits are established by the Secretary of Health and Human Services. These payments shall under no circumstances exceed the facility's customary charges to the general public for services.

C. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

D. Alabama does not adjust rates based on service deficiencies or quality of service; no payment will be made for services rendered at an inappropriate level of care.

E. Providers who participate in the program shall accept as payment in full those amounts paid to them in accordance with the State Plan.

VI. Compliance with Provisions, Methods and Standards

In order to assure compliance with its regulations, the Alabama Medicaid Agency has established certain penalties which may be assessed at its discretion, the details of which are fully set out in the Agency Administrative Code.

VII. Miscellaneous

A. The Alabama Medicaid Agency will utilize appropriate methods of notifying the public concerning proposed, substantial changes in methods and/or standards, and prior to the implementation of any substantial change in methods and/or standards, the public will have an opportunity to review and comment on the proposed changes.

B. Detailed information regarding the reimbursement methodology and related matters appears in Chapter 42 of the Alabama Medicaid Agency Administrative Code.

Addendum to B. 10.(d) (Page 16)

Depreciation will be computed using the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets. Equipment that has been amortized through a use allowance will have its remaining book value determined and that value will be depreciated over its remaining useful life. Should the remaining useful life be zero, the book value will be written off in the current year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

DEFINITION OF A CLAIM

Effective Date: 10/01/80

Within the guidelines of 42 CFR 447.45(b), the definition of a claim for each of the several types of covered services provided recipients through the Alabama Medicaid Program is included in this attachment. In each of the definitions the term "claim form" is used. This does not limit the submission of claims to hardcopy. Submission of claims in any Medicaid prior approved method is acceptable. This could include magnetic tape, diskettes, or continuous form of billing.

Effective Date: 10/01/14

1. Inpatient Hospital Claim

An inpatient Hospital Claim is a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim for each in-hospital period in a calendar year. Except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or additional inpatient days that have been authorized for deliveries, or children who have been referred for treatment as the result of an EPSDT screening. For rate year beginning October 1, 2014, the 16 day reimbursement limit will no longer be effective.

Effective Date: 10/01/11

2. Outpatient Hospital Claim

An Outpatient Hospital Claim is a bill for all services except physician charges provided a recipient by a provider and submitted for payment on an approved Medicaid claim for each visit, except for chemotherapy, physical or occupational, and radiation therapy which may be span billed for services rendered during a calendar month.

Effective Date: 07/01/87

3. Rural Health Clinic Claim

A Rural Health Clinic Claim is a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim form for each encounter.

Effective Date: 07/01/87

4. Renal Dialysis Center Claim

A Renal Dialysis Center Claim is a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim form. A claim may be for each visit or span billed for services provided during a calendar month.

Effective Date: 10/01/83

5. Physicians Claim

A Physician Claim is a bill for all services identified by procedure codes provided to a recipient over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

6. Laboratory Claim

A Laboratory Claim is a bill for all services provided a recipient over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

7. X-ray Services Claim

An X-ray Services Claim is a bill for all services provided a recipient over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

Effective Date: 10/01/83

8. Home Health, Family Planning, Prenatal, Hearing Aid, EPSDT Claim

A claim for each of these covered services will be a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim form.

Effective Date: 10/01/83

9. Durable Medical Equipment/Supplier Claim

A Durable Medical Equipment/Supplier Claim is a bill for item(s) by a procedure code, provided a recipient for one date or over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

10. Optometric Claim

An Optometric Claim is a bill for services by a provider over a period of time for all procedures provided a recipient and submitted on an approved claim form.

11. Ambulance Service Claim

An Ambulance Service Claim is a bill for all services provided to a recipient for one date of ambulance service by a provider and submitted for payment on an approved Medicaid claim form.

Effective Date: 10/01/83

12. Pharmacy Claim

A pharmacy Claim is a bill for one prescription filled for a recipient by a pharmacy provider and submitted on an approved Medicaid Pharmacy Claim Form or any Medicaid Claim form.

A medical claim which contains one or more injectable drug line items is deemed to be one drug claim, for administrative reimbursement purposes only.

Effective Date: 10/01/83

13. Dental Claim (EPSDT)

An EPSDT related dental claim is a bill for all services identified by procedure code provided to a recipient over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

14. Group Claim

A Group Claim is a claim for long term care services which lists each recipient as a line item for a period of service by a provider and is submitted for payment on an approved Medicaid claim form.

15. Medicare Crossover Claim

A Medicare Crossover Claim is a bill for services provided a recipient by a provider and submitted on an approved federal form containing an Alabama Medicaid Recipient Number, together with a copy of the explanation of Medicare benefits paid, with a copy of the explanation of Medicare benefits paid, including deductible and coinsurance paid. (With prior approval of Medicaid, the submission may be by tape-to-tape transfer.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

REQUIREMENTS FOR THIRD PARTY LIABILITY –
IDENTIFYING LIABLE RESOURCES

A. The State Medicaid Agency meets the requirements of 42 CFR 433.138 and 433.139.

B. The State Medicaid Agency meets the requirements for identifying liable third party resources in the following way(s):

1. For the data exchanges required in 42 CFR 433.138(d)(1), (d)(3), (d)(4), and (f) and the diagnosis and trauma code edits required in §433.138(e):
    a. The State Medicaid Agency obtains wage and earning information through a data exchange with the Alabama Department of Industrial Relations (SWICA and Workmen's Compensation) and the Department of Public Safety (Motor Vehicle). Employment data identified thru the SSA Wage and Earnings File and by the IV-A is referred to the Third Party Liability (TPL) Section by the certifying agency for Medicaid upon identification of same.
    b. TPL data received as a result of SWICA and SSA and IV-A data exchanges is incorporated into the Eligibility File and TPL database within thirty days of receipt of verification of coverage. Health insurance information identified by Medicaid certifying agencies during application and redetermination is incorporated into the Eligibility File and TPL database by the TPL Division within sixty days of receipt of verification of coverage.
    c. The data exchange with the Alabama Department of Public Safety identifies drivers and pedestrians only if a trauma code is listed on the accident report. The data exchange produces a listing of matches which TPL submits to the Department of Public Safety with a request for copies of each accident report. The accident reports are reviewed by the TPL staff within thirty days of receipt. If potential TPL is identified, a case file is established within thirty days of identification of TPL. Pertinent insurance information is documented in the TPL database if there is a reasonable expectation that the carrier will pay future related medical expenses.
    d. The State Medicaid Agency monitors diagnosis and trauma codes through internal reports. See 42 CFR 433.138(c). These reports determine which codes yield the highest return on TPL payments. This process is undertaken on a daily basis. Using these reports, TPL staff will ensure subrogation interest/assignment is identified and determined.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

REQUIREMENTS FOR THIRD PARTY LIABILITY –
IDENTIFYING LIABLE RESOURCES

1. For the follow-up measures for identifying third party liability resources required in 42 CFR 433.138(g)(1) and (g)(2), the State Medicaid Agency implements these follow-up mechanisms to identify legally liable third party resources:

    a. The State Medicaid Agency requests that members provide TPL information when applying for Medicaid. The Medicaid Agency accepts TPL information directly from members, providers, Social Security Administration (SSA) local offices, and others.

    b. The State Medicaid Agency conducts a daily, weekly, and monthly match to identify members who also have commercial insurance. The State Medicaid Agency conducts regular matches with CMS's Territory & States Beneficiary Query (TBQ) and SSA's State Verification and Exchange System (SVES) files to identify members who are eligible for Medicare. The State Medicaid Agency conducts regular matches with the Defense Enrollment Reporting System (DEERS) to identify members who are eligible for Tricare. The State Medicaid Agency uses the Public Assistance Reporting Information System (PARIS) to identify individuals who may be enrolled in another state Medicaid program. See 42 CFR 433.138(g)(2).

AL-08-003
SUPPLEMENT TO
ATTACHMENT 4.22-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ALABAMA

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25) The Medicaid agency assures that the State has in effect laws requiring third parties to provide the State with coverage eligibility and claims data under 1902(a)(25)(I) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ALABAMA

Requirements for Third Party Liability –
Payment of Claims

The Medicaid Agency's TPL program primarily functions as a cost avoidance system. Claims for medical services, unless excluded by federal law, are cost-avoided when a third party liability policy exists with the Medicaid Agency's claims payment system. Claims paid prior to the identification and input of third party coverage into the claims payment system are pursued by a vendor for post-payment recovery.

Provider compliance with third party billing requirements (42 CFR 433.139(b)(3)(ii)(C)):

The State Plan as referenced herein requires providers to bill liable third party coverage. When a probable third party coverage is established, the Medicaid Agency notifies the provider that the claim was cost-avoided due to the existence of TPL. TPL cost-avoided claims are identified with an Explanation of Benefit Code which provides the third party payer information on the provider's Remittance Advice. Exceptions to the cost-avoidance process:

- claims as specified in 42 CFR 433.139(b)(3)(i),
- when the pursuit of liable third party can result in harm to the beneficiary (Good Cause exemption under 42 CFR 433.147(c)(2)),
- any approved cost-avoidance waiver.

The Medicaid Agency will apply cost-avoidance procedures for prenatal services, including labor, delivery and postpartum care services.

In accordance with 42 CFR 433.139(b)(3)(i), the Medicaid Agency will make payment without regard to potential TPL for pediatric preventive services and will seek recovery from the carrier, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost-avoidance for 90 days. If a provider has billed a third party for pediatric preventive services and has not received a response, the provider will be required to submit proof that at least 90 days has passed from the date of service before the Medicaid Agency will pay the claim.

Where the third party liability is derived from a parent whose obligation to provide medical support is being enforced by the State Title IV-D Agency, providers will be required to bill the third party before filing Medicaid. If a provider has billed a third party and has not received payment, the provider will be required to submit proof that at least 100 days has passed from the date of service before the Medicaid Agency will pay the claim.

Providers are monitored for compliance with insurance billing requirements through post payment recovery by a vendor. If a report of prior payment to either the provider or insured person is received, the amount paid by the carrier is recouped from the provider.

Third Party Collection Procedures to be Cost-Effective:

The Medicaid Agency's MMIS uses a $5 threshold in determining whether to seek recovery from a health insurance carrier for all except drug claims. Claims which do not exceed a paid amount of $5 are placed in an automated suspense file. The suspense file is read monthly to identify recipients whose accumulated claims exceed the threshold. Claims are carried on the suspense file for up to twelve months. The Medicaid Agency's MMIS uses a $25 threshold for drug claims. Drug claims are accumulated monthly for submission to a third party. Accumulated claims which exceed a $25 paid amount are submitted to the third party carrier.

The Medicaid Agency uses a $250 threshold for casualty recovery. Once a liable third party is identified, the entire recipient paid claims history is reviewed. If the accumulated total of paid claims related to the injury third party exceeds $250, recovery is sought from the liable third party.

The Medicaid Agency ensures that regulations are in effect that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules. These regulations comply with the provisions of section 202 of the Consolidated Appropriations Act, 2022.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Alabama

1906 of the Act **State Method on Cost Effectiveness of Employer–Based Group Health Plans (Private Health Insurance Buy In – PHIBI)**

The State of Alabama will use two methods to determine the likely cost effectiveness of a group health plan:

1. Cost effectiveness based on Average Expenditure Projection

The likely cost effectiveness of a health insurance policy to Medicaid may be determined by comparing the cost of the premiums, deductibles, copayments, plus the administrative cost of analysis and processing by the state against the average Medicaid expenditure for a recipient in the recipient's eligibility classification for types of service(s) covered under the policy. The premium shall be paid even if the policy covers other non-Medicaid person(s), but only to the extent when the premium portion of the recipient cannot be paid separately from the non-covered person.

2. Cost Effectiveness Based on Actual Expenditures

The likely cost effectiveness of health insurance may be established by documentation of actual expenditures (Explanation of Benefits) from the insurer which, based on a recipient's existing condition, are likely to continue and that exceed the cost of the policy as described in paragraph 1. above for the period of anticipated Medicaid coverage.

Methodology for Determining Cost Effectiveness of the Health Insurance Premium Payment Program (HIPP)

The purpose of the Health Insurance Premium Payment Program (HIPP) is to identify Medicaid cases in which payment of employer related group health insurance premiums would be cost effective.

In order to qualify for HIPP, a person must be eligible for and receiving Medicaid, participate in a group health insurance plan, and payment of the health insurance premium by the Alabama Medicaid Agency must be determined to be cost effective. The recipient or a person acting on the recipient's behalf shall cooperate in providing information necessary for the Agency to establish availability and the cost effectiveness of group health insurance.

THIRD PARTY LIABILITY

Once a person is determined eligible for HIPP, the insurance will be treated as a third party resource. The policy will be listed on our third party file. The group insurance will become the primary payer. Medicaid will provide for payment of items and services to Medicaid recipients under the State Plan that are not covered in the group health plan.

COST EFFECTIVENESS

Cost effectiveness means that Medicaid payments for certain services will probably be greater than the cost of paying the health insurance premiums for those services. When determining if a health insurance plan is cost effective, the following data will be considered:

- The cost of the insurance premium, coinsurance and deductibles
- The category of services covered under the insurance plan, including exclusions for pre-existing conditions, etc.
- The average anticipated Medicaid use, by coverage group, for person covered under the insurance plan
- The specific health related circumstances of the person covered under the insurance plan

COVERAGE OF NON-MEDICAID ELIGIBLE FAMILY MEMBERS

When it is determined to be cost effective, the Agency will pay for health insurance premiums for Non-Medicaid eligible family members if a Non-Medicaid eligible family member must be enrolled in the health insurance plan in order to obtain coverage for the Medicaid eligible family members. The needs of the person/persons not covered by

Medicaid will not be taken into consideration in determining cost effectiveness. Payments of deductibles and coinsurance will not be made on behalf of family members who are not Medicaid eligible.

EXCEPTIONS TO PAYMENT

Health insurance premiums will not be paid under the following circumstances:

- The insurance plan is that of an absent parent
- The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (example: $50.00 per day for hospital services instead of 80 percent of the charge)
- The insurance plan is a school plan offered on the basis of attendance or enrollment at the school
- The person/persons covered under the plan are not Medicaid eligible on the date the decision regarding eligibility for HIPP is made.

DUPLICATE POLICIES

When more than one health insurance plan or policy is available to a recipient, the Agency will pay for the most cost effective plan. In a situation where a recipient is on Buy-in (the Agency is paying the cost of the Medicare Part A or Part B premiums), the cost of premiums for a Medicare supplemental insurance policy may be paid if the Agency determines it to be cost effective.

DISCONTINUATION OF PREMIUM PAYMENTS

When a recipient loses Medicaid eligibility, premiums payments will be discontinued as of the month of Medicaid ineligibility. When part of a household loses Medicaid eligibility, a review will be completed in order to determine whether or not payment or the health insurance premium continues to be cost effective.

EFFECTIVE DATE OF PREMUM PAYMENT

The effective date of premium payments for cost effective health insurance plans will be the month in which the plan is determined to become cost effective as long as all necessary requirements have been met (e.g., Cobra forms are on file with employer, HIPP application is on file with Third Party, etc.).

REVIEW OF COST EFFECTIVENESS

A redetermination of cost effectiveness will be completed at least every six months for employer related group health plans and annually for non-employer related group health plans. Also, redeterminations will be completed whenever a predetermined premium rate, deductible or coinsurance increases, a person covered under the policy loses full Medicaid eligibility or there is a decrease in services covered under the policy.

TIME FRAMES FOR DETERMINING COST EFFECTIVENESS

The Agency will determine cost effectiveness of the insurance plan and notify the recipient of the decision regarding payment of premiums within 45 days of the receipt of the HIPP application. Additional time may be granted when, for reasons beyond the control of the Agency or recipient, information needed to establish cost effectiveness cannot be obtained within the 45 day period.

NOTICES

An adequate notice shall be provided to the Medicaid recipient or person responsible for the recipient under the following circumstances:

- To inform the recipient of the initial decision regarding cost effectiveness and premium payment
- To inform the recipient that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the policy
- To inform recipient that premium payments are being discontinued because the insurance plan is no longer available (e.g., employer drops insurance coverage or the insurance company terminates the policy)
- To inform recipient that payment of premiums is being discontinued because the Agency has determined the policy is no longer cost effective.

RATE REFUND

The Agency will be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due, because of lower than anticipated claims for any period of time for which the Agency paid the premium.

State/Territory Alabama

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A) and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of Section 1902(y)(1), Section 1902(y)(2)(A), and Section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State Plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State Plan; or 2. provide that no payment will be made under the State Plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State Plan and provide that no payment will be made under the State Plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A)	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State Plan with respect to any individual admitted to such hospital after the end of such 3-month period.
	__X__ The above standards are required but coverage is limited to Medicaid eligible recipients up to age 21.

State/Territory Alabama

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A) and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of Section 1902(y)(1), Section 1902(y)(2)(A), and Section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
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	__X__ The above standards are required but coverage is limited to Medicaid eligible recipients up to age 21.

State: Alabama

Citation
1932(e)
42 CFR 428.726

Sanctions for MCOs and PCCMs

(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

___ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ALABAMA

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ALABAMA

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

1. SSI Recipients

Monthly eligibility cards are forwarded to the address provided the Alabama Medicaid Agency through the State Data Exchange (SDX) update tapes. When the local Social Security Office presents an SSI assistance check to an eligible individual reporting to the office, the recipient's name and the local Social Security Office postal box number is provided the main Social Security headquarters in Baltimore, Maryland. This information is then entered on the next SDX update tape for Alabama. The Medicaid eligibility file (AMAES) is updated from the SDX tape with the appropriate Social Security Office address which is then imprinted on the Medicaid monthly eligibility card and forwarded to the local Social Security Office identified in the address.

2. Non-SSI Recipients

Monthly eligibility cards for programs administered by the Department of Human Resources may be forwarded to the DHR County office where the Medicaid recipient was certified eligible, or at recipient's choice the card will be mailed to a recipient's postal box or to the U.S. Post Office General Delivery Section indicated in the address.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ALABAMA

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) Concerning advance directives. If applicable, States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

YOUR RIGHT TO MAKE YOUR OWN DECISIONS ABOUT MEDICAL CARE

(A summary of the law in Alabama)

This document was prepared by the Alabama Department of Public Health, the Alabama Medicaid Agency, and the Alabama Attorney General, with the assistance of health law experts throughout the state. It is provided to you in compliance with federal law.

DECIDING FOR YOURSELF WHAT TREATMENTS YOU WANT

---**IF** you are nineteen years of age or older,

---**AND IF** you are reasonably alert and mentally capable of understanding the consequences of your own decisions,

THEN Alabama law allows you to stop hospitals, nursing homes, physicians, nurses, or other health care workers from performing a medical procedure or treatment on you against your wishes. This includes life-saving emergency treatments, life-sustaining treatments, and the provision of food and liquids by artificial means. Examples of life-saving treatments include cardio-pulmonary resuscitation ("CPR") and cardiac defibrillation, which is a procedure where electric current is applied to your chest to stabilize your heartbeat. Examples of life-sustaining treatments include mechanical ventilators to assist breathing and kidney dialysis. Other life-sustaining treatments include administration of food and liquids, which may be done through a tube inserted in your nose and down your throat, or through a tube surgically placed directly into your stomach.

Deciding about your health care

If you are 19 or older, the law says you have the right to decide about your medical care.

If you are very sick or badly hurt, you may not be able to say what medical care you want.

If you have an advance directive, your doctor and family will know what medical care you want if you are too sick or hurt to talk or make decisions.

What is an advance directive?

An advance directive is used to tell your doctor and family what kind of medical care you want if you are too sick or hurt to talk or make decisions. If you do not have one, certain members of your family will have to decide on your care.

You must be at least 19 years old to set up an advance directive. You must be able to think clearly and make decisions for yourself when you set it up. You do not need a lawyer to set one up, but you may want to talk with a lawyer before you take this important step. Whether or not you have an advance directive, you have the same right to get the care you need.

Types of advance directives

In Alabama you can set up an Advance Directive for Health Care. The choices you have include:

A living will is used to write down ahead of time what kind of care you do or do not want if you are too sick to speak for yourself.

A proxy can be part of a living will. You can pick a proxy to speak for you and make the choices you would make if you could. If you pick a proxy, you should talk to that person ahead of time. Be sure that your proxy knows how you feel about different kinds of medical treatments.

Another way to pick a proxy is to sign a durable power of attorney for health care. The person you pick does not need to be a lawyer.

You can choose to have any or all of these three advance directives: Living will, proxy and/or durable power of attorney for health care.

Hospitals, home health agencies, hospices and nursing homes usually have forms you can fill out if you want to set up a living will, pick a proxy or set up a durable power of attorney for health care. If you have questions, you should ask your own lawyer or call your local Council on Aging for help.

When you set up an advance directive

Be sure and sign your name and write the date on any form or paper you fill out. Talk to your family and doctor now so they will know and understand your choices. Give them a copy of what you have signed. If you go to the hospital, give a copy of your advance directive to the person who admits you to the hospital.

What do I need to decide?

You will need to decide if you want treatments or machines that will make you live longer even if you will never get better. An example of this is a machine that breathes for you.

Some people do not want machines or treatments if they cannot get better. They may want food and water through a tube or pain medicine. With an advance directive, you decide what medical care you want.

Talk to your doctor and family now

The law says doctors, hospitals and nursing homes must do what you want or send you to another place that will. Before you set up an advance directive, talk to your doctor ahead of time. Find out if your doctor is willing to go along with your wishes. If your doctor does not feel he or she can carry out your wishes, you can ask to go to another doctor, hospital or nursing home.

Once you decide on the care you want or do not want, talk to your family. Explain why you want the care you have decided on. Find out if they are willing to let your wishes be carried out.

Family members do not always want to go along with an advance directive. This often happens when family members do not know about a patient's wishes ahead of time or if they are not sure about what has been decided. Talking with your family ahead of time can prevent this problem.

You can change your mind any time

As long as you can speak for yourself, you can change your mind any time about what you have written down. If you make changes, tear up your old papers and give copies of any new forms or changes to everyone who needs to know.

For help or more information:

Alabama Commission on Aging	1-800-243-5463
Choice in Dying	1-800-989-9455

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: ALABAMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: ALABAMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: ALABAMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: ALABAMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

X Specified Remedy	____ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: ALABAMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

X Specified Remedy	____ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE/TERRITORY: ALABAMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

X Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: ALABAMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

X Specified Remedy	____ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: ALABAMA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF ALABAMA

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

NON-APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF ALABAMA

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

NON-APPLICABLE

* U.S. Government Printing Office : 1991 - 312-149/40413

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

DEFINITION OF SPECIALIZED SERVICES

Definitions

Specialized Services for Mental Illness - 24 Hour Inpatient Psychiatric Treatment including individualized comprehensive treatment planning by an interdisciplinary team under the direction/supervision of a QMHP and physician.

Specialized Services for Mental Retardation - Continuous, aggressive, and consistent training to assist an individual to maintain or improve the current level of functioning in order for the individual to function with as much self-determination and independence as possible and to potentially prevent or decrease regression of functioning. Specialized Services for MR include individualized planning by an interdisciplinary team under the direction/supervision of a QMPR to assist an individual to achieve or maintain optimal functioning.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

CATEGORICAL DETERMINATIONS

Upon Level I identification of one of the following conditions:

1. Need for Convalescent Care of 120 days or less
2. Terminal Illness with life expectancy of 6 months or less
3. Comatose
4. Ventilator Dependent
5. Functioning Only at Brain Stem Level
6. Cerebellar Degeneration
7. Advanced Amolytrophic Lateral Sclerosis
8. Huntington's Disease

and written certification by the attending physician of the above condition and that the NF applicant is not a danger to himself or others, the applicant may be admitted directly to a NF.

If the NF applicant has been identified as having any Suspected Mental Illness or Mental Retardation/Related Conditions, a determination of Specialized Services must be made although the individual may be admitted to a NF without a Level II evaluation before admission. Immediately upon admission to the NF, the NF must contact the OBRA Screening Office for a Specialized Services Determination to be made within seven working days from the date of admission to the NF.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The Division of Licensure and Certification (DLC) as a subsidiary of Public Health maintains a vital interest and active involvement in the education of the staff, residents and their representatives in facilities throughout the state. The programs provided by DLC for the educational benefit to meet the needs of the populous include:

(1) Active participation in a Standardization Committee which jointly includes members of this division and members of the Alabama Nursing Home Association. This committee meets regularly to discuss issues pertinent to this area of medical care. Through questions and comments submitted by the Nursing Home Association, DLC responds with answers which are discussed and resolved in writing. The questions, answers and pertinent areas of discussion are then distributed to the long term care facilities and surveyors throughout this state in an effort to increase communication and consistency.

(2) DLC Newsletters are published to address pertinent information, issues, and clarification of information. Also addressed are changes within regulations, requirements and survey procedures.

(3) Statewide tours addressing the CLIA regulations will be conducted by this agency who will be responsible for regulating these facilities.

(4) DLC staff participates in workshops around the state as requested by various industry members.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriations of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The Alabama Department of Public Health, Division of Licensure and Certifications, Complaint Unit is responsible for this function. The complaint unit consists of eight (will be increased by 100% by FY93) Licensure & Certification nurses (RN's) specially trained to investigate abuse, neglect and misappropriation of residents funds or property, two Steno II administrative support personnel, and is supervised by a Licensure and Certification officer with extensive experience in health care management, i.e., Hospital and Nursing Home Administration. A one page Abuse Allegation Report form has been developed and distributed to the nursing home industry to be utilized to report an allegation of abuse, neglect or misappropriation of property. (See attachment one) This unit also has in-state toll free: "Hotline" that is manned 8 hours per day on normal duty days. The Hotline also has voice mail capability for recording allegations seven days per week, twenty-four hours per day. When an allegation is received in the complaint unit, a case number is assigned and the allegation is reviewed by the supervisor. The supervisor prioritizes the cases by degree of severity and assigns a survey nurse to make an unannounced on-sight visit to investigate the allegation. *(See Priority Below) When the nurse is unable to obtain sufficient evidence to substantiate the allegation the facility management and the accused is notified in writing, and the case is closed. When sufficient evidence is found, the allegation is substantiated and the process of adding the accused's name to the abuse register is implemented. A permanent file is established (and maintained in the complaint unit) which contains a complete report and supportive documentation of the allegation investigation, and disposition of each case.

*Priority 1. (Initiate investigation within two working days of receipt) Physical abuse, temporary or permanent injury, disability or death.

*Priority 2. (Initiate investigation within 45 days) All abuse, neglect or misappropriation of resident's property that do not fall into priority 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Territory: Alabama

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The division of Licensure and Certification has in place a Security Plan to assure that all long term care on-site surveys are unannounced. All reasonable steps have been taken to avoid giving notice. Computer listings of surveys (recertification and follow-up) are distributed only to directors and supervisors that require this information. The schedule is distributed to the Director of Field Services and Quality Assurance, Director of Health Care Facilities Section, Director of Long Term Care Section, Long Term Care Supervisors, Complaint Supervisor, and Life Safety Code Supervisor. These schedules are carefully protected by the management staff. Surveyors are not given a copy of the schedule and do not have access to the schedule. Assignments are given to surveyors the Friday prior to a Monday survey or on the Monday prior to a Tuesday survey. Advance hotel/motel reservations are not made; however, if room availability is questionable, the surveyor may make an advance reservation using a fictitious name.

In checking out a State Motor Pool vehicle, surveyors do not list the cities involved in travel. This assures confidentiality of the survey towns. Surveyors are notified upon employment with the Division of the requirement that all surveys are unannounced. They are made aware of the federal monetary fine as well as DLC's policy of disciplinary actions for divulging and unannounced survey.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Territory: Alabama

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The state agency has a comprehensive Quality Assurance program which was designed to increase accuracy in documentation and consistency in surveyors' interpretations of regulation as well as reduce surveyor inconsistency in the application of survey results. This program is multi-dimensional and consists of 5 major areas.

1. Supervisor contact with team on survey
   During surveys in which significant problems are found, there is supervisor contact with the team as information is being collected and observations are being made. This increases consistency in the quality and type of information that is obtained, as well as the quality of information that is documented in the Statement of Deficiencies.

2. Review Process
   Deficiencies go through a multi-step review process.

   a. A Peer Review of the deficiency by another surveyor is done prior to the deficiency being submitted.

   b. The team leader reviews the entire packet of information including the Statement of Deficiencies prior to submitting the packet to a long term care supervisor.

   c. A Long Term Care RN Supervisor reviews the survey information for:

      1.) Accuracy
      2.) Completeness
      3.) Content and clarity. Deficiencies are edited if needed.
      4.) Information and examples in the deficiencies are tracked back to the worksheets for substantiation and verification of findings.

3. Training based on QA results

   The state agency's RN training officer is appraised of the results of QA reviews; and surveyor training needs are developed into inservice programs and presented to staff.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Territory: Alabama

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

4. Monitoring Surveys

State agency Long Term Care RN Supervisors monitor selected surveys to determine adequacy of surveyor performance and to determine whether the survey process is accomplished according to HCFA directives. Recommendations to individual surveyors as well as the entire team may be made by the RN supervisor.

5. Standardization Committee

The state agency has developed committees consisting of professionals from each discipline within DLC: Nursing, Dietary, Pharmacy, Social Services and Activity Therapy to increase consistency in the professionals' interpretation of the regulations. Representatives from these committees, as well as DLC management staff meet with professional representatives of the Alabama Nursing Home Association to discuss common concerns attempting to further increase professional communication and consistency in Long Term Care issues. The result of the meetings are published in written Question and Answer form and sent to all long term care facilities in Alabama as well as all surveyors in the state.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Territory: Alabama

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

(Also see (c) & (d) on preprint

PRIORITY 3 - General non-health care related complaints that are referred to an Ombudsman.

These complaint investigations are conducted at the facility during an unannounced on-site visit by a Licensure & Certification nurse assigned to the complaint unit. Investigations are documented on appropriate state agency and HCFA forms plus a complete narrative report is written to address each allegation, the findings of the investigation, a conclusion as to the validity of the allegation and the disposition of the complaint. Complaint investigation files are maintained by facility and are separate from the facility Licensure and Certification file. Follow-up surveys are conducted within 90 days after a complete investigation that results in a Statement of Deficiencies being issued. These follow-up visits are conducted by the LTC certification survey teams in conjunction with routine survey visits when possible. When LTC routine surveys are not scheduled within this allotted 90 day period, the follow-ups are conducted by the complaint unit nurses. The facility complaint file is reviewed by the LTC survey team immediately prior to a routine certification surveyor follow-up visit to a facility. A tracking log for all complaints is maintained on a computer and is updated on a daily basis.

Section 6032 State Plan Preprint
Page 1 of 4

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

Citation 1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan Amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

4.42 Employee Education About False Claims Recoveries

It will be the responsibility of the Program Integrity Division of the Agency to monitor the compliance of entities with Section 6032 of the DRA. Each December, the Program Integrity Division Director will receive a list of entities that received or made payments of at least $5 million or more during the previous federal fiscal year. This list will be provided by the Agency's fiscal agent.

(a) Initially, letters will be sent to all entities listed requiring copies of their written policies regarding the False Claims Act as specified in section 1902(a)(68)(A). The entities should comply by April 30, 2007, or 15 days from the date of the letter, whichever is sooner.

(b) Thereafter, only those entities added to the list each year will be required to provide entire copies of their written policies to the Agency. Entities that have previously been determined to be a covered entity and required to submit a written policy and continue still to be a covered entity will be required to sign a yearly statement attesting that their written policy remains in effect and no changes have been made to the policy with entire copies of their written policies required to be submitted only every five years.

(c) All entities are responsible for monitoring state legislation to ensure that their written policies remain up to date and accurate. If there are changes to policies, the entity has 30 days from the date of the change to provide copies of the updated policies to the Agency.

(d) Non-compliance with Section 6032 of the DRA by an entity will result in payments to that entity being withheld until compliance is attained.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alabama

Citation 1902(a)(69) of the Act, P.L. 109-171 (section 6034)	4.43	Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

GUY HUNT
Governor

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

CAROL A. HERRMANN
Commissioner

January 1, 1991

STATEMENT OF COMPLIANCE CERTIFICATION
FOR THE MEDICAL ASSISTANCE PROGRAM OF ALABAMA

I hereby certify that it is the policy of the Alabama Medicaid Agency to apply the same requirements for eligibility and participation to everyone, and no distinction is made in providing services offered by this Agency regardless of race, color, creed, national origin, religion, sex, age, or handicap. All contracted facilities are available without distinction to all employees, Medicaid recipients, and visitors regardless of race, color, creed, national origin, religion, sex, age, or handicap. All persons and organizations having occasion either to refer Medicaid recipients for assistance or to recommend this Agency are advised to do so without regard to race, color, creed, national origin, sex, age, or handicap. The Alabama Medicaid Agency fully complies with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Carol A. Herrmann

Carol A. Herrmann, Commissioner

TN NO. 91-1 DATE/RECEIPT 12/19/90
SUPERSEDES DATE/APPROVED 1-10-91
TN NO. _____ DATE/EFFECTIVE 1-1-91

ALABAMA MEDICAID AGENCY

METHODS OF PROGRAM ADMINISTRATION
TO ASSURE NONDISCRIMINATION UNDER
TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

A. Purpose

To describe the Alabama Medicaid Agency methods of administration to assure that each program or activity for which it receives federal financial assistance is operated in accordance with Title VI of the Civil Rights Act of 1964.

B. Policy

The Alabama Medicaid Agency shall comply with the provisions of Title VI of the Civil Rights Act of 1964 and 45 C.F.R., Part 80, and will monitor compliance by providers to ensure that their employees and Medicaid patients are not, on the grounds of race, color, creed, religion, national origin, age, sex, or disability, excluded from participation in, or denied the benefits of, or otherwise subjected to discrimination under any program or service administered for the Alabama Medicaid program.

C. Dissemination of Information

1. Alabama Medicaid recipients, providers and the general public are informed through brochures, pamphlets, official communications, and public media announcements that Medicaid services are provided on a non-discriminatory basis as required under Title VI regulations.

2. The Alabama Medicaid Agency ensures that its staff fully understands their Title VI responsibilities through in-service training, bulletin board notices, and distribution of policies and rules.

D. Administration

1. The Alabama Medicaid Agency does not utilize any criteria or methods of administration which will result in, or have the effect of, distinction being made between individuals solely on the basis of race, color, creed, religion, national origin, age, sex, or disability, or which have the effect of impairing accomplishment of Title VI requirements of the Medicaid Program with respect to recipients and providers of service.

2. The opportunity to participate in the Alabama Medicaid Agency planning, advisory and policy deliberations, which are an integral part of the Alabama Medicaid Program, is available to all members of the staff.

3. The Alabama Medicaid Agency has implemented and maintains complaint policies and procedures that provide appropriate recourse for any aggrieved person without regard to race, color, creed, religion, national origin, age, sex, or disability through an Affirmative Action Committee and a Grievance Committee. A current Affirmative Action Plan is available to all employees.

4. The Alabama Medicaid Agency Civil Rights Coordinator will be responsible for Title VI Civil Rights compliance by the Alabama Medicaid Agency and its providers of services. The Coordinator will handle complaints of discrimination, and the dissemination of information pertaining to Title VI Civil Rights.

5. The Alabama Medicaid Agency will schedule and perform visits on-site to institutional and non-institutional providers to review compliance with the Civil Rights Act, and to investigate Title VI complaints by Medicaid recipients or employees of Alabama Medicaid providers of services, as appropriate.

6. It is the policy of the Alabama Medicaid Agency that recruiting, employment, training, promotion, remuneration, and all personnel administrative practices shall be conducted without regard to race, color, creed, national origin, religion, age, sex, politics, or handicap. A formal orientation program will be established which will include the Agency Grievance Procedures and Affirmative Action policies and procedures. Training selection methods and records of participants will be reviewed at the Agency level to ensure that they are nondiscriminatory and are preparing women and minorities in accordance with Affirmative action goals.

7. To ensure that the utmost importance is placed on Civil Rights enforcement, the Executive Commissioner of the Alabama Medicaid Agency has been designated as the Civil Rights Coordinator for the Agency.

8. The procedures to be administered during the processing of complaints which may be filed involving alleged violations of Title VI provisions have been developed and provided Medicaid staff, the Medicaid recipients and Medicaid District Offices for public display. The procedures have also been published in newspapers for the general public.

2. The Alabama Medicaid Agency staff is informed of Agency rehabilitation policy through bulletin board notices, in-service training programs, and new employee orientation procedures.

D. Administration

1. The Alabama Medicaid Agency is in compliance with Section 504, Rehabilitation Act, for employment of the handicapped and ensures barrier-free access to Medicaid operating locations.

2. The Alabama Medicaid Agency shall make available to the Office for Civil Rights, or other appropriate agencies, all information necessary to determine the Alabama Medicaid Agency's compliance with Title VI, Civil Rights Act, and Section 504, Rehabilitation Act.

Rec'd __/__/__ HCFA # 86-19

Date Approved 11/18/86

Eff. Date 10/1/86 OBS. ____-____

METHODS OF ADMINISTRATION

SECTION 504 OF THE REHABILITATION ACT OF 1973

Alabama Medicaid Agency - Methods of Administration

A. Purpose

The Alabama Medicaid Agency, agrees that within the provisions of Section 504 of the Rehabilitation Act of 1973, hereinafter called Section 504, and regulation 45 C.F.R. Section 84.1 et seq, that the Medical Assistance Program shall be conducted in such manner that no qualified handicapped individual shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

B. Policy

1. In determining the type of activities, services, financial aids, or other benefits, or facilities which will be provided or included under the Alabama Medicaid Program, The Alabama Medicaid Agency will not utilize any criteria or method of administration which will result in or have the effects of distinction being made between individuals solely on the basis of handicap. The Alabama Medicaid Agency will not establish any rule; regulation, or procedure that will interfere with or reduce compliance with Section 504, Rehabilitation Act of 1973.

2. The Alabama Medicaid Agency has executed and submitted HHS Form 641, Assurance of Compliance, to the Federal Office of Civil Rights, Washington, D.C.

C. Responsibility

The Alabama Medicaid Agency shall be responsible for the following:

a. Investigate complaints of discrimination within the Alabama Medicaid Agency.

b. Disseminating of Section 504 information to Alabama Medicaid Agency staff, beneficiaries, and interested members of the general public.

c. Maintaining documentation of compliance actions taken and the submission of any such reports as might be required by the Department of Health and Human Services (HHS) to ensure compliance with the regulation through state methods of administration.

Rec'd __/__/__ HCFA# 86-19

Date Approved 11/18/86

Eff. Date 10/1/86 ORS

d. Acting as liaison between the Office of Civil Rights, handicapped groups and other community groups concerned with the delivery of services.

e. Providing training and technical assistance on Section 504 and the needs of the handicapped.

f. Making determinations concerning compliance with program requirements.

g. Conducting compliance reviews of vendors and institutional providers of services.

h. Maintaining and monitoring essential files and records relative to implementation and surveillance of Title VI and Section 504 programs.

D. Section 504, Rehabilitation Act of 1973

1. The Alabama Medicaid Agency Compliance Responsibility

The following actions will be taken to ensure that the Alabama Medicaid Agency staff fully understands its responsibilities and obligations under Section 504:

a. General provisions of Section 504 will be distributed to all employees.

b. Alabama Medicaid Agency managers shall receive Section 504 orientation.

c. Appropriate notices pertaining to Section 504 shall be posted on Alabama Medicaid Agency bulletin boards.

d. Section 504 information shall be included with in-service training programs.

2. Provider Compliance

The following procedures and policies have been established in recognition that the Alabama Medicaid Agency's obligation for compliance extends to providers of Medicaid services, service contractors, and other providers of services:

a. The Alabama Medicaid Administrative Code is available to all Medicaid providers; it includes a list of applicable requirements and states that non-discrimination is prohibited.

b. In cooperation with provider associations in-service programs as appropriate may be conducted on a statewide basis to ensure understanding of their responsibilities under Section 504.

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c. All freestanding intermediate care facilities (Medicaid only) and any other Medicaid only health facilities are required to submit a signed HHS Form 641, Assurance of Compliance, for certification.

d. Participants have been instructed that the submission of a signed Assurance of Compliance does not automatically indicate that actual compliance with Section 504 and the regulation is acceptable.

e. Continuous evaluation will be made of contracted institutions.

f. All other providers are reviewed on a complaint basis.

3. Informing Beneficiaries

In accordance with 45 C.F.R. Section 84.1, et seq, the Alabama Medicaid Agency has taken the following steps to notify beneficiaries and the general public of Section 504 compliance policy:

a. Alabama Medicaid Agency brochures, pamphlets, contracts, and other similar materials contain a statement of compliance with Section 504.

b. All customary referral sources have been advised in writing that services and benefits are provided in a nondiscriminatory manner.

c. A statement of compliance is posted in appropriate places within the Alabama Medicaid Agency. All providers have been provided appropriate compliance statements with instructions to post them in prominent places.

d. Assistance from local civic groups and organizations interested in the handicapped will be requested for appropriately notifying persons as needed with impaired hearing or vision of the Alabama Medicaid Agency's compliance policy.

4. Complaint Policies and Procedures

The Alabama Medicaid Agency has established a grievance procedure providing appropriate due process (hearing) to any aggrieved employee, without regard to race, color, creed, national origin, age, sex, religion, political affiliation or handicap. All employees have been informed of this grievance procedure and copies of the procedure are posted on employee bulletin boards. The Affirmative Action Committee has the responsibility of ensuring complaints are processed in accordance with the established procedure. It is Alabama Medicaid Agency policy that: Rec'd __/__/__ ECFA# 86-19

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a. To be considered by the Alabama Medicaid Agency Affirmative Action Committee, a complaint must be filed within six (6) months from the date of the alleged discriminatory act(s).

b. The Alabama Medicaid Agency Commissioner may extend the time for filing the complaint if the complaint is alleged to be of a continuing nature.

c. No person who has filed a complaint, testified, assisted, or participated in any manner in the investigation of any complaint will be intimidated, threatened, coerced, or discriminated against.

d. The Chairman of the Affirmative Action Committee shall bring any complaints to the attention of the Civil Rights Coordinator and the Commissioner of the Alabama Medicaid Agency.

e. All complaints shall be investigated in a prompt and thorough manner.

f. The established grievance procedure provides for intermediate levels of discussion, fact-finding, hearing and appeal to the grievance committee if necessary. Recommendations of the Committee will be made to the Commissioner.

g. The complainant will be advised in a timely fashion of the findings regarding his/her complaint and be advised of the rights to appeal to the Office of Civil Rights if not satisfied with the Alabama Medicaid Agency decision.

h. Documentation (records) will be maintained of the complaint, details of the investigation, and the actions taken.

i. In those cases where the complaint is initially filed with the Office for Civil Rights, the Alabama Medicaid Agency will conduct the investigation and provide the Office for Civil Rights with full information.

5. Nondiscrimination Policy

The Alabama Medicaid Agency has adopted and published a policy of compliance with Section 504 which effectively communicates that the services, financial assistance and other benefits of its programs are provided in a nondiscriminatory manner.

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E. Recruiting and Employment Practices

1. The State of Alabama operating under the State Merit System employs the following policies in accordance with the

Rehabilitation Act of 1973 and the Alabama Administrative Code, Section 670-X-4.

a. There is a training program for supervisors working with the handicapped (vocational rehabilitation).

b. The Code of Alabama, 1975 Section 21-7-8, provides for reaching the handicapped on the employment register through special appointments.

c. The Code of Alabama, 1975 Section 21-4-1, et seq requires barrier-free design in buildings constructed with State funds.

2. It is the policy of the Alabama Medicaid Agency that no qualified handicapped person shall, on the basis of handicap, be subjected to discrimination in employment.

3. The recruiting, employment, and all personnel administrative practices shall be conducted in compliance with Section 504.

4. Preemployment information is regulated by a standard State of Alabama application for examination. Any handicap information submitted will be used in an affirmative manner as provided by the Code of Alabama, 1975 Section 36-26-16.

a. Rates of pay and benefits to handicapped individuals shall be equal to those provided to non-handicapped, i.e., leaves of absence, sick leave, insurance, etc.

b. Training and educational leave are provided employees in a nondiscriminatory manner.

F. Planning, Advisory, and Policy Boards

It is the policy of the Alabama Medicaid Agency that the opportunity to participate as members of planning, advisory, and policy boards is available to all persons in a nondiscriminatory manner.

G. Continuing Compliance

1. There are established policies and procedures for implementing and monitoring all aspects of the Alabama Medicaid Agency's operations in accordance with this plan to ensure continuing compliance.

2. The Alabama Medicaid Agency program managers have developed policies and procedures for implementing and monitoring compliance with Section 504 by providers and service contractors. Monitoring procedures include, but are not limited to the following areas:

a. Location of offices and facilities

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b. Manner of assignments of applicants/clients/staff.

c. Dissemination of program information.

d. Criteria for acceptance into programs.

e. Referral of clients to other agencies and facilities.

f. Referral sources.

g. Utilization of handicapped vendors.

h. Use of volunteers, consultants, etc.

i. Applications for assistance.

j. Provision of services.

k. Handicapped persons on planning, advisory, and policy boards.

l. Program accessibility to handicapped persons.

m. Auxiliary aids for persons with impaired sensory, manual, or speaking skills.

H. Program Accessibility

1. The Alabama Medicaid Agency assures that no qualified handicapped person be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination under any of its programs or those of its vendors because the facilities are inaccessible to or unusable by handicapped persons.

2. The Alabama Medicaid Agency has achieved program accessibility where possible through such methods (alternative to structural changes) as provided in the regulation.

3. Any additional facilities leased or rented by Medicaid will be accessible and usable by the handicapped in accordance with Section 504.

4. The Alabama Medicaid Agency will provide information for interested persons, including persons with impaired vision or hearing to obtain information as to the existence and location of services, activities and facilities that are accessible to and usable by handicapped persons.

5. Procedures are established for implementing and monitoring Medicaid's policy of assuring that vendors with fewer than fifteen (15) employees not meeting the requirements for program accessibility refer qualified handicapped persons to other providers where those services are accessible.

I. Corrective Requirements

The Alabama Medicaid Agency shall comply with federal requirements for corrective action in the following manner:

1. Evaluate existing policies and practices.

2. Modify and/or adopt new policies to comply with Section 504 as appropriate.

3. Identify current handicapped employees.

4. Recruit, employ and provide benefits in accordance with State and Federal requirements and within the provisions of the policies and practices of the State Merit System.

5. Take appropriate remedial steps, as provided under the policies adopted to comply with Section 504 and as provided under the rules and regulations under the State Merit system.

6. Take appropriate steps to ensure that services provided to non-handicapped are equal to those provided the handicapped.

J. Compliance Records

1. The Alabama Medicaid Agency shall collect and maintain handicap data and information on its operations which will show the extent to which handicapped persons are participating in all aspects of the Medicaid programs. Medicaid shall require such data and information from providers and other participants of its programs.

2. The Alabama Medicaid Agency shall make available to the Office for Civil Rights all data and information necessary to determine compliance with Section 504 of the Rehabilitation Act.

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Date Approved 11/18/86
Eff. Date 10/1/86 OBS. ___-___

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

__X__ The state assures coverage of COVID-19 vaccines and administration of the vaccines.[1]

__X__ The state assures that such coverage:

1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

____ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.

__X__ The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.

__X__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines.

Additional Information (Optional):

[1] The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.

Reimbursement

__X__ The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for COVID-19 vaccines and their administration for each applicable Medicaid benefit:

The vaccine administration schedule can be found on the website, www.medicaid.alabama.gov, on the Newsroom tab under ALERTs, dated December 29, 2020 labelled "COVID-19 Vaccine Information for Pharmacy Billing"

__X__ The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

__X__ The state's rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

__X__ Medicare national average, OR

____ Associated geographically adjusted rate.

__X__ The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location :

Pharmacy will follow the state policy for the ingredient cost which can be found on the website, www.medicaid.alabama.gov, on the Newsroom tab under ALERTs, dated August 18, 2021 labelled "COVID-19 Vaccine Information for Pharmacy Billing", and follows the Medicare rates for administration. Reimbursement rates for non-Pharmacy codes can be found on the website, www.medicaid.alabama.gov, on the Provider tab under Fee Schedules, labelled "COVID-19 Testing and Specimen Collection Vaccine Administration, and Monoclonal Antibody Infusion"

__X__ The state's fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

____The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

__X__ The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.

___The state's rate is as follows and the state's fee schedule is published in the following location

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

__X__ The state assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

__X__ The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(l) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

Pharmacy: Allowable for 4 tests per member per month; overrides available.

___ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

__X__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__X__ The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

> The fee schedule for COVID-19 testing can be found on the website, www.medicaid.alabama.gov, on the Provider tab under Fee Schedules, labelled "COVID-19 Testing and Specimen Collection Vaccine Administration, and Monoclonal Antibody Infusion"

__X__ The state is establishing rates for COVID-19 testing pursuant to pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

Medicare national average, OR
Associated geographically adjusted rate.

__X__ The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

> Pharmacy follows the state plan policy for the ingredient cost plus professional dispensing fee: Attachment 4.19-B, page 3. The rates can be found online here: https://www.medicaid.alabamaservices.org/alportal/NDC%20Look%20Up/tabId/5/Default.aspx
>
> Reimbursement rates for non-Pharmacy codes can be found on the website, www.medicaid.alabama.gov, on the Newsroom tab under Fee Schedules dated April 13, 2022 named "COVID-19 Testing and Specimen Collection Vaccine Administration, and Monoclonal Antibody Infusion."

__X__ The state's fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

____The payment methodologies for COVID-19 testing for providers listed above are described below:

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

__X__ The state assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

__X__ The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(l) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

___ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

__X__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Coverage for a Condition that May Seriously Complicate the Treatment of COVID

__X__ The state assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

__X__ The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(l) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

___ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

__X__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__X__ The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 treatment for each applicable Medicaid benefit

The fee schedule for COVID-19 treatment can be found on the website, www.medicaid.alabama.gov, on the Provider tab under Fee Schedules, labelled "COVID-19 Testing and Specimen Collection Vaccine Administration, and Monoclonal Antibody Infusion"

___ The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

__X__ The state's rates or fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0021	**STATE:** Alabama

Pages or sections of pages being superseded by S14, S25, S28, S30, S51, S52, S53, S54, and S55, and related pages or sections of pages being deleted as obsolete

State Plan Section	Complete Pages Removed	Partial Pages Removed
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Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 4b Page 12 Page 13 Page 13a Page 14 Page 14a Page 21 Page 23 Page 23b	Page 2, A.2.b Page 2, A.2.c Page 2a, A.3 Page 5, A.10 Page 20, B.14 Page 23c, B.21 Page 25, C.4
Supplement 1 to Attachment 2.2-A	Page 1	
Attachment 2.6-A	Page 3b Page 11a Page 16 Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a(i) and (iii) Page 6 related to AFDC recipients, pregnant women, infants, and children Page 7, 1.a(1) and (2) Page 12, C.1.e(2) Page 18, C.5.e Page 25, C.11.a(3)
Supplement 1 to Attachment 2.6-A	Pages 1, 1.1, and 2-4	
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Supplement 8a to Attachment 2.6-A	Page 3	Pages 1, 2 and Addendum related to AFDC recipients, pregnant women, infants, and children
Supplement 8b to Attachment 2.6-A		Pages 2 and 3 related to AFDC recipients, pregnant women, infants, and children
Supplement 11a to Attachment 2.6-A	Page 1	
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Supplement 14 to Attachment 2.6-A	Page 1	
Supplement 15 to Attachment 2.6-A	Pages 1 and 2	

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards — S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

Medicaid Eligibility

	Household size	Standard ($)	
+	1	124	X
+	2	155	X
+	3	187	X
+	4	221	X
+	5	257	X
+	6	289	X
+	7	328	X
+	8	361	X
+	9	394	X
+	10	427	X
+	11	460	X
+	12	492	X
+	13	526	X
+	14	559	X
+	15	591	X
+	16	624	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 33

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

(•) Statewide standard

( ) Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	111	X
+	2	137	X
+	3	164	X
+	4	194	X
+	5	225	X
+	6	252	X
+	7	287	X
+	8	315	X
+	9	344	X
+	10	372	X
+	11	400	X
+	12	428	X
+	13	457	X
+	14	485	X
+	15	513	X
+	16	541	X

Additional incremental amount

◉ Yes ○ No

Increment amount $ 28

The dollar amounts increase automatically each year

○ Yes ◉ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option **S13a**

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option **S13a**

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option **S13a**

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives **S25**

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☐ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ Options relating to the definition of caretaker relative (select any that apply):

☐ Options relating to the definition of dependent child (select the one that applies):

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

Medicaid Eligibility

- (•) The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ( ) The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ( ) The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ( ) The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

- (•) A percentage of the federal poverty level: [13] %
- ( ) The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ( ) The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ( ) The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ( ) Other dollar amount

[■] Income standard chosen:

Indicate the state's income standard used for this eligibility group:

- ( ) The minimum income standard
- (•) The maximum income standard
- ( ) The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.
- ( ) Another income standard in-between the minimum and maximum standards allowed

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

( ) Yes (•) No

PRA Disclosure Statement

Medicaid Eligibility

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Pregnant Women **S28**

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for this eligibility group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

(•) 185% FPL

[■] Income standard chosen

Indicate the state's income standard used for this eligibility group:

The minimum income standard

The maximum income standard

(•) Another income standard in-between the minimum and maximum standards allowed.

The amount of the income standard for this eligibility group is: 141 % FPL

[■] There is no resource test for this eligibility group.

[■] Benefits for individuals in this eligibility group consist of the following:

All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

(•) Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

Pregnancy-related services, as defined at 42 CFR 440.210 (a)(2), include prenatal, delivery, postpartum and family planning services, as well as services related to conditions which may complicate pregnancy.

Full Medicaid coverage is provided only for pregnant women with income at or below the income limit described below:

[■] Minimum income limit for full Medicaid coverage

The minimum income standard used for full coverage under this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

[☑] The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

[■] Maximum income limit for full Medicaid coverage

Medicaid Eligibility

(•) The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) (qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent standard.

( ) The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) (qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent standard.

( ) The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The amount of the maximum income limit for full Medicaid coverage is:

(•) A percentage of the federal poverty level: 13 %

( ) A dollar amount

[■] Income limit chosen for full Medicaid coverage:

(•) The minimum income limit

( ) The maximum income limit

( ) Another income limit in-between the minimum and maximum standards allowed.

[■] Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

( ) Yes (•) No

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19 **S30**

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for infants under age one is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

(•) 185% FPL

☒ Income standard chosen

The state's income standard used for infants under age one is:

( ) The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

The amount of the income standard for infants under one is: 141 % FPL

☒ Income standard for children age one through age five, inclusive

☒ Minimum income standard

Medicaid Eligibility

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 141 % FPL

☑ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

◉ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 133% FPL

Enter the amount of the maximum income standard: 141 % FPL

■ Income standard chosen

Medicaid Eligibility

The state's income standard used for children age six through eighteen is:

(•) The maximum income standard

( ) If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

( ) Yes (•) No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage **Adult Group**	**S32**
1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	
The state covers the Adult Group as described at 42 CFR 435.119. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Former Foster Care Children **S33**

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

■ **Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

☑ The state attests that it operates this eligibility group under the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under age 26.

■ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

■ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

○ Yes ◉ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage **Individuals above 133% FPL**	**S50**
1902(a)(10)(A)(ii)(XX) 1902(hh) 42 CFR 435.218	
Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage **Optional Coverage of Parents and Other Caretaker Relatives**	**S51**

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21 **S52**

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

(•) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

■ Be under age 21, or a lower age, as defined within the reasonable classification.

■ Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

■ Not be eligible and enrolled for mandatory coverage under the state plan.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(•) Yes ( ) No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(•) Yes ( ) No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

☑ The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

An attachment is submitted.

Current Coverage of All Children under a Specified Age

Medicaid Eligibility

The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

○ Yes ◉ No

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

◉ Yes ○ No

Indicate the reasonable classifications of children that were covered in the state plan in effect as of March 23, 2010 with income standards higher than the mandatory standards used for the child's age, using age limits and income standards that are not more restrictive than used in the state plan as of as March 23, 2010 and are not less restrictive than used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

Reasonable Classifications of Children **S11**

☒ Individuals for whom public agencies are assuming full or partial financial responsibility.

☒ Individuals placed in foster care homes by public agencies

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

☐ Individuals placed in foster care homes by private, non-profit agencies

☒ Individuals placed in private institutions by public agencies

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

☐ Individuals placed in private institutions by private, non-profit agencies

☐ Individuals in adoptions subsidized in full or part by a public agency

☐ Individuals in nursing facilities, if nursing facility services are provided under this plan

☐ Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

☒ Other reasonable classifications

	Name of classification	Description	Age Limit	
+	Inpatients in public psychiatric facility	Inpatients receiving active treatment in public psychiatric facility	Under age 21	X

Enter the income standard used for these classifications. The income standard must be higher than the mandatory standard for the child's age. It may be no lower than the income standard used in the state plan as of March 23, 2010 and no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Click here once S11 form above is complete to view the income standards form.

Individuals placed in foster care homes by public agencies

■ Income standard used

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

■ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Medicaid Eligibility

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals placed in private institutions by public agencies

☑ Income standard used

☑ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☑ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Inpatients in public psychiatric facility

☑ Income standard used

☑ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☑ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

○ Yes ◉ No

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

Medicaid Eligibility

○ Yes ◉ No

☒ There is no resource test for this eligibility group.

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance **S53**

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

[■] Are under the following age (see the Guidance for restrictions on the selection of an age):

(•) Under age 21
( ) Under age 20
( ) Under age 19
( ) Under age 18

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(•) Yes ( ) No

[■] Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

( ) Yes (•) No

[■] There is no resource test for this eligibility group.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer. Mail Ston C4-26-05. Baltimore. Marvland 21244-1850

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage **Optional Targeted Low Income Children**	**S54**

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage **Individuals with Tuberculosis**	**S55**
1902(a)(10)(A)(ii)(XII) 1902(z)	
Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage **Independent Foster Care Adolescents**	**S57**

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

○ Yes ◉ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage **Individuals Eligible for Family Planning Services**	**S59**
1902(a)(10)(A)(ii)(XXI) 42 CFR 435.214	
Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214. ○ Yes ◉ No	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: AL-13-0022-MM3	**STATE: Alabama**
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S10 - MAGI Income Methodology	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Notwithstanding any other provisions of the Alabama Medicaid State Plan, the financial eligibility methodologies described in State Plan Amendment AL-13-0022-MM3 will apply to all MAGI-based eligibility groups covered under Alabama's Medicaid State Plan. The MAGI financial methodologies set forth in 42 CFR § 435.603 apply to everyone except those individuals described at 42 CFR § 435.603(j) for whom MAGI-based methods do not apply. This State Plan Amendment supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies — S10

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ○ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted as herself, plus one.
- ◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size
- ○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☐ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☐ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

○ Yes ◉ No

Medicaid Eligibility

☑ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

◉ Age 19

○ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Alabama**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

AL-15-0009

Proposed Effective Date

11/01/2015 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435.116;1902(a)(10)(A)(i)(III) and (IV);1902(a)(10)(A)(ii)(I), (IV) and (IX);1931(b) and (d);1920

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 0.00
Second Year	2017	$ 0.00

Subject of Amendment

To provide full Medicaid coverage for pregnant women.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  Governor's designee on file via letter with CMS.

Signature of State Agency Official

Submitted By:	**Stephanie Lindsay**
Last Revision Date:	**Dec 4, 2015**
Submit Date:	**Dec 2, 2015**

Medicaid Eligibility

State Name: Alabama

OMB Control Number: 0938-1148

Transmittal Number: AL - 15 - 0009

Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Pregnant Women **S28**

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women -** Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (*Once entered and approved by CMS, the minimum income standard cannot be changed.*)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for this eligibility group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

(•) 185% FPL

☒ Income standard chosen

Indicate the state's income standard used for this eligibility group:

The minimum income standard

The maximum income standard

(•) Another income standard in-between the minimum and maximum standards allowed.

The amount of the income standard for this eligibility group is: 141 % FPL

☒ There is no resource test for this eligibility group.

☒ Benefits for individuals in this eligibility group consist of the following:

(•) All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

☒ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

Yes (•) No

PRA Disclosure Statement

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | AL2019MS0001O | AL-19-0012 | MIGRATED_HH.AL HHS

Package Header

Package ID AL2019MS0001O

SPA ID AL-19-0012

Submission Type Official

Initial Submission Date 8/30/2019

Approval Date 9/25/2019

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives Alabama Medicaid will end the Health Home program on September 30, 2019 and will implement the Alabama Coordinated Health Network (ACHN) Program beginning October 1, 2019 based on the authority of the recently approved 1915 (b) waiver AL-09. The ACHN will provide a single care coordination delivery system that effectively links patients, providers, and community resources in seven defined regions of the state.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2020	$0
Second	2021	$0

Federal Statute / Regulation Citation

ACA Section 2703 (1945 of the Social Security Act)

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | AL2019MS0001O | AL-19-0012 | MIGRATED_HH.AL HHS

Package Header

Package ID	AL2019MS0001O	**SPA ID**	AL-19-0012
Submission Type	Official	**Initial Submission Date**	8/30/2019
Approval Date	9/25/2019	**Effective Date**	N/A
Superseded SPA ID	N/A		

Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | AL2019MS0001O | AL-19-0012 | MIGRATED_HH.AL HHS

Package Header

Package ID	AL2019MS0001O	**SPA ID**	AL-19-0012
Submission Type	Official	**Initial Submission Date**	8/30/2019
Approval Date	9/25/2019	**Effective Date**	N/A
Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- (•) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- ( ) Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | AL2019MS0001O | AL-19-0012 | MIGRATED_HH.AL HHS

Package Header

Package ID AL2019MS0001O

SPA ID AL-19-0012

Submission Type Official

Initial Submission Date 8/30/2019

Approval Date 9/25/2019

Effective Date N/A

Superseded SPA ID N/A

Name of Health Homes Program:

MIGRATED_HH.AL HHS

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- ( ) Yes
- (•) No

Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations: While these programs will end, the ACHN will provide a single care coordination delivery system that will effectively link patients, providers, and community resources in 7 defined regions of the state.

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | AL2019MS0001O | AL-19-0012 | MIGRATED_HH.AL HHS

Package Header

Package ID AL2019MS0001O

SPA ID AL-19-0012

Submission Type Official

Initial Submission Date 8/30/2019

Approval Date 9/25/2019

Effective Date N/A

Superseded SPA ID N/A

SAMHSA Consultation

Name of Health Homes Program

MIGRATED_HH.AL HHS

☑ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
8/6/2019

Health Homes Program Termination - Phase-Out Plan

MEDICAID | Medicaid State Plan | Health Homes | AL2019MS0001O | AL-19-0012 | MIGRATED_HH.AL HHS

CMS-10434 OMB 0938-1188

Package Header

Package ID	AL2019MS0001O	**SPA ID**	AL-19-0012
Submission Type	Official	**Initial Submission Date**	8/30/2019
Approval Date	9/25/2019	**Effective Date**	9/30/2019
Superseded SPA ID	AL-14-001		
	User-Entered		

Provide a description of the phase-out or transition plan for the Health Homes Program that is being terminated

Describe the reason for termination

Alabama Medicaid will end the Health Home program on September 30, 2019 and will implement the Alabama Coordinated Health Network (ACHN) Program beginning October 1, 2019 based on the authority of the recently approved 1915 (b) waiver AL-09

Describe the overall approach the state will use to terminating the program

The Health Home population will continue to receive care coordination services by nurses and social workers through the ACHN program.

Indicate method of termination

- (•) The state will terminate all participants from the Health Homes Program on the same date
- ( ) The state will phase-out the termination of participation in the Health Homes Program

Termination effective date

9/30/2019

Describe the process the state will use to transition all participants and how referrals will be made to other health care providers

The ACHN will provide a single care coordination delivery system that effectively links patients, providers, and community resources in seven defined regions of the state.
The Health Home population will continue to receive care coordination services by nurses and social workers through the ACHN program. With the implementation of the ACHN, Primary Care Physician's (PCPs) will continue to provide a medical home and the focus will be on activity and quality. PCPs that engage with the ACHN will qualify for bonus payments related to quality, cost effectiveness and Patient Centered Medical Home recognition. PCPs that engage with the ACHN, will also receive a higher payment for certain Evaluation and Management codes. Medicaid is hopeful these changes will produce a more quality driven program.
Care coordination services will be provided for the recipients that were previously in the Health Home Program by the ACHN Program beginning November 1, 2019. Before then, recipients can contact the ACHN recipient number for assistance. If you have any questions about this notification of termination, please contact Jerri Jackson at 334-242-5630 or via e-mail at jerri.jackson@medicaid.alabama.gov.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 9/25/2019 11:03 AM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | AL2020MS0002O | AL-20-0012

Package Header

Package ID AL2020MS0002O

SPA ID AL-20-0012

Submission Type Official

Initial Submission Date 9/30/2020

Approval Date 5/28/2021

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID AL-20-0012

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Eligibility Determinations of Individuals Age 65 or Older or Who Have Blindness or a Disability	7/1/2020	NEW
MAGI-Based Methodologies	7/1/2020	AL-14-0006
Non-MAGI Methodologies	7/1/2020	91-36;93-29;96-05;10-006
Mandatory Eligibility Groups	7/1/2020	NEW
Qualified Medicare Beneficiaries	7/1/2020	AL-00-01
Specified Low Income Medicare Beneficiaries	7/1/2020	AL-00-01
Qualifying Individuals	7/1/2020	AL-00-01
Optional Eligibility Groups	7/1/2020	NEW
Individuals Eligible for Cash Except for Institutionalization	7/1/2020	AL-00-01
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules	7/1/2020	AL-00-01

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | AL2020MS0002O | AL-20-0012

Package Header

Package ID AL2020MS0002O

SPA ID AL-20-0012

Submission Type Official

Initial Submission Date 9/30/2020

Approval Date 5/28/2021

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives Seeking a section 1902(r)2 of the Social Security Act to apply an income disregard for Census related activities for non-Modified Adjusted Gross Income (MAGI) groups.

Seeking State Plan option to have a "reasonable method to include a prorated portion of reasonable predictable future income" to apply a RPC methodology to prorate expected future changes for 12 months for MAGI-based methodologies group.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2020	$0
Second	2021	$0

Federal Statute / Regulation Citation

1902 (r) 2; 42 CFR 435.603(h)(2); 42 CFR 435.603(h)(3)

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | AL2020MS0002O | AL-20-0012

Package Header

Package ID	AL2020MS0002O	**SPA ID**	AL-20-0012
Submission Type	Official	**Initial Submission Date**	9/30/2020
Approval Date	5/28/2021	**Effective Date**	N/A
Superseded SPA ID	N/A		

Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | AL2020MS0002O | AL-20-0012

Package Header

Package ID	AL2020MS0002O	**SPA ID**	AL-20-0012
Submission Type	Official	**Initial Submission Date**	9/30/2020
Approval Date	5/28/2021	**Effective Date**	N/A
Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- ○ Public notice was not federally required and comment was not solicited
- ○ Public notice was not federally required, but comment was solicited
- ◉ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☐ Email to Electronic Mailing List or Similar Mechanism
- ☐ Website Notice
- ☐ Public Hearing or Meeting
- ☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	
Public Notice	9/25/2020 2:45 PM EDT	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
No items available		

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☑ Eligibility
  - **Summarize comments:** Reasonable Predictable Changes for seasonal/temporary income
  - **Summarize response:** None
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | AL2020MS0002O | AL-20-0012

Package Header

Package ID AL2020MS0002O

SPA ID AL-20-0012

Submission Type Official

Initial Submission Date 9/30/2020

Approval Date 5/28/2021

Effective Date N/A

Superseded SPA ID N/A

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (•) Yes
- ( ) No

[x] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

[ ] All Indian Health Programs

[ ] All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

[x] All Indian Tribes

Date of consultation:	Method of consultation:
8/2/2019	Letter

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
Indian Tribal Certified Letter and Envelope mailed 073119	9/6/2019 10:43 AM EDT	

Indicate the key issues raised (optional)

[ ] Access

[ ] Quality

[ ] Cost

[ ] Payment methodology

[ ] Eligibility

[ ] Benefits

[ ] Service delivery

[ ] Other issue

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 6/1/2021 9:10 AM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | AL2022MS0001O | AL-22-0007

Package Header

Package ID AL2022MS0001O

SPA ID AL-22-0007

Submission Type Official

Initial Submission Date 7/7/2022

Approval Date 1/13/2023

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives The primary purpose for this amendment is to extend postpartum coverage to pregnant Medicaid recipients from 60-days to 12-months.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2023	$30300000
Second	2024	$30300000

Federal Statute / Regulation Citation

PL 117-2, Sec 9812

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | AL2022MS0001O | AL-22-0007

Package Header

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Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Governor's designee on file via letter with CMS.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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AL - Submission Package - AL2022MS0001O - (AL-22-0007) - Eligibility

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage

MEDICAID | Medicaid State Plan | Eligibility | AL2022MS0001O | AL-22-0007

CMS-10434 OMB 0938-1188

Package Header

Package ID	AL2022MS0001O	**SPA ID**	AL-22-0007
Submission Type	Official	**Initial Submission Date**	7/7/2022
Approval Date	1/13/2023	**Effective Date**	10/1/2022
Superseded SPA ID	NEW		
	User-Entered		

The state provides continuous eligibility for pregnant individuals and extended postpartum coverage in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan, without regard to any changes in income that otherwise would result in ineligibility, through the last day of the month in which a 60-day postpartum period (beginning on the last day of the pregnancy) ends. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.

B. Optional 12-Month Postpartum Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan while pregnant (including during a period of retroactive eligibility) through the last day of the month in which a 12-month postpartum period (beginning on the last day of the pregnancy) ends. The 12-month postpartum continuous eligibility option applies for the period beginning on the effective date of this reviewable unit and is available through March 31, 2027 (or other date as specified by law).

- (•) Yes
- ( ) No

1. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.
2. Full benefits are provided for a pregnant or postpartum individual under this option. This includes all items and services covered under the state plan (or waiver) that are not less in amount, duration, or scope than, or are determined by the Secretary to be substantially equivalent to, the medical assistance available for an individual described in subsection 1902 (a)(10)(A)(i) of the Act.
3. Continuous eligibility is provided to pregnant individuals eligible and enrolled under the state plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

    a. The individual requests voluntary termination of eligibility;

    b. The individual ceases to be a resident of the state;

    c. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse or perjury attributed to the individual; or

    d. The individual dies.

C. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.