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State/Territory Name: Alabama

State Plan Amendment (SPA) #: 20-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

April 2, 2021

Ms. Stephanie McGee Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

RE: State Plan Amendment (SPA) 20-0013

Dear Ms. Azar:

We have reviewed the proposed amendment to Attachment 4.19-A/B of your Medicaid State plan submitted under transmittal number 20-0013. Effective October 1, 2020, the Alabama Medicaid Agency proposes to apply the reimbursement methodology for inpatient and outpatient hospital services for State fiscal year 2021 in a manner consistent with that used in fiscal year 2020. The reimbursement methodology would have expired September 30, 2020. Analysis showed that the overall change in payments for the first year is nominal compared to total IP/OP payments (approx. 1%).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of October 1, 2020. We are enclosing the CMS-179 (HCFA-179) and the amended approved plan pages.

If you have any questions, please call Christie Erickson at (410)786-8441.

Sincerely,

[redacted]

For
Rory Howe
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: AL-20-0013

2. STATE: Alabama

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 C.F.R. 430 Subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY 2021 $186,583,329 $267,798,044
b. FFY 2022 $ 92,563,737 $63,513,834

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A pages 3A, 6G, 6H, 6I, 6I.1, 6I.2, 6I.3, 6I.6, 6J, and 8D
Attachment 4.19-B, pages 8.a, 8.1, 8.2, 8.3, 8.3.a, and 8.3.b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A pages 3A, 6G, 6H, 6I, 6I.1, 6I.2, 6I.3, 6I.6, 6J, and 8D
Attachment 4.19-B, pages 8.a, 8.1, 8.2, 8.3, 8.3.a, and 8.3.b

10. SUBJECT OF AMENDMENT:
The primary purpose for this amendment is to allow the Alabama Medicaid Agency to apply the reimbursement methodology for inpatient and outpatient hospital services for State fiscal year 2021 in a manner consistent with that used in fiscal year 2021.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor's designee on file via letter with CMS

12. SIGNA[redacted]GENCY OFFICIAL:

13. TYPED NAME:
Stephanie McGee Azar

14. TITLE:
Commissioner

15. DATE SUBMITTED: 11/23/2020

16. RETURN TO:
Stephanie McGee Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 4/2/21

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted] For

21. TYPED NAME:
Rory Howe

22. TITLE:
Acting Director, Financial Management Group

23. REMARKS:

The state has authorized pen and ink changes to box 7 as noted below:
FY 2021: $267,798,044
FY 2022: $63,513,834

FORM HCFA-179 (07-92)

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

METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/20

(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, 2021, 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

STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

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.

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

METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/20

(j) For the period October 1, 2017, through September 30, 2021, 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 2020 the total inpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2007, divided by the total paid inpatient hospital days incurred by that hospital in state fiscal year 2007, multiplied by the inpatient hospital days incurred by each hospital during fiscal year 2021.

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 2021 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 $17,173,938 and $53,514,092 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 $17,173,938 and $53,514,092 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 $17,173,938 and $53,514,092 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 Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap. During the period October 1, 2020 through September 30, 2021, Inpatient Access payments for the rate year ending September 30, 2021 to Children's Hospital of Birmingham, Alabama shall be limited to an amount that when added to estimated base payments equals 119% of estimated cost of inpatient services to Medicaid beneficiaries. Any UPL Gap that is not paid to providers including Childrens of Alabama through access payments will be allocated to a separate pool that will be paid in a subsequent period in proportion to the hospital that generated the pool.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA
METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

(k) For the period October 1, 2020, through September 30, 2021, 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 ^ 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.

(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 2021 to determine the amount Medicare would have paid for Medicaid services.

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

METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

(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 four State Fiscal Years and the fiscal year ended during the preceding cost reporting year and preceding rate year. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.

(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'.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA
METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

(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). 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, 2020, through September 30, 2021, 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA
METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

(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 2021. The inpatient charges will be obtained at the revenue code level.

(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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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(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, 2020, through September 30, 2021, 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA
METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

(n) For the period October 1, 2020, through September 30, 2021, 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 $275 per Medicaid inpatient day paid based on the Medicaid days per the cost report ending during the State Fiscal Year 2019.

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

METHOD FOR PAYMENT INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/20

(f) For the period from October 1, 2020, to September 30, 2021, 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.

13. Outpatient Hospital Services
Effective Date: 10/01/2020

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, 2021, 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.

(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, 2021, 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, 2021, 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, 2021, 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.

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, 2021, 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 were 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 for SFY 2021. 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.)

(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 between the State Fiscal Year ended during the rate year used for cost reports and the preceding State Fiscal Year for outpatient hospitals in Alabama. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.

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

(7) 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.

(8) 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, 2021 is zero.

(9) 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.

(10) Access payments are paid quarterly.