

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.

A. Alternative Payment Methodology (APM) Reimbursement

Beginning October 1, 2019, RHCs that are Alabama Coordinated Health Network (ACHN) Certified are eligible to receive an APM reimbursement in addition to the PPS rate, but only if the following statutory requirements are met. First, the APM must be agreed to by Alabama Medicaid and by each individual RHC that participates in the program. Second, the methodology must result in a total payment (PPS plus APM) that is at least equal to the amount to which the RHC is entitled under the Medicaid PPS.

ACHN Certified Delivering Healthcare Professionals (DHCPs) Enhanced Payment

ACHN Certified DHCPs will receive an enhanced payment for:

- i. an initial prenatal visit in the first trimester and/or
- ii. a post-partum visit.

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 \$15 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 1, 2019 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 2019. Subsequent payments will be made on a quarterly basis.
- vi. Level One Quality Performance Payment for the period between October 1, 2019 and September 30, 2021:
 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 October 1, 2021 and beyond:
 1. The Agency's quarterly payments beginning with the October 2021 payment will be based on actual quality measure performance as soon as the previous calendar year's performance has been calculated (anticipated date twelve months after the start of the second contract year). For example, the quarterly payments made in October 2021, January 2022, April 2022, and July 2022 will be based on the actual quality measure performance calculated for the period between January 1, 2020 and December 31, 2020.

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 procedure codes without an established Medicaid rate, the Alabama Medicaid Agency will base rates on the current Medicare rate, and if not available the average commercial rate. Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private physicians and other practitioners. The Agency's fee schedule 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 at Birmingham
 - b. The University of South Alabama
 - c. Children's of AlabamaThe 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, 2018 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 2018 Medicaid utilization and the 2018 Medicare based rates, the established teaching physician percentage is 190.1%.
 - 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.

Effective Date: 10/01/19

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 99201 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 15 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 in at least two (2) quarterly Medical Management Meetings and one webinar/facilitation exercise 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 Delivering Health Care Professionals (DHCPs) with the ACHN Program:

- a. DHCPs, which include OB/GYNs, Nurse Midwives, and other physicians, 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 Eligible Individual’s (EI’s) care plan; and
 - iii. Engagement in the DHCP selection and referral process.
- b. Certification requirements will be monitored on a monthly basis. ACHNs will report monthly to the Agency a list of DHCPs who they have contracted and engaging with to provide maternity services. DHCPs 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

III. Rates for ACHN Certified PCPs:

ACHN Certified PCPs will receive higher rates for certain E&M billing codes (99201-99205, 99211-99215, 99241-99245) that are considered reimbursable by Alabama Medicaid. The ACHN Certified Rate fee schedule is effective October 1, 2019. All rates are published on the Agency's website at

www.medicaid.alabama.gov.

To view the ACHN 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 DHCPs:**

- a. ACHN Certified DHCPs will receive an enhanced payment for:
 - i. an initial prenatal visit in the first trimester and/or
 - ii. a post-partum visit.

V. **ACHN Certified Provider Performance Payments**

Performance Payments for ACHN Certified PCP Groups:

A performance payment pool will be established in the amount of \$15 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 1, 2019 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 2019. Subsequent payments will be made on a quarterly basis.
- vi. **Level One Quality Performance Payment** for the period between October 1, 2019 and September 30, 2021:
 - 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 October 1, 2021 and beyond:
 - 1. The Agency's quarterly payments beginning with the October 2021 payment will be based on actual quality measure performance as soon as the previous calendar year's performance has been calculated (anticipated date twelve months after the start of the second contract year). For example, the quarterly payments made in October 2021, January 2022, April 2022, and July 2022 will be based on the actual quality measure performance calculated for the period between January 1, 2020 and December 31, 2020.

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 IEPs and IFSPs by the total number of children with IEPs and IFSPs.

(B) Transportation Services Payment Methodology

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

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

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

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

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

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

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

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

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

3) Net Direct Costs and Indirect costs are combined.

- (C). Certification of Costs Process:
On a quarterly basis, each provider will certify through its cost report, its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.
- (D). Cost Report Process:
For Medicaid services listed in Paragraph (a) 1-10 provided in schools during the state fiscal year, each LEA provider must complete the following:
- 1) Quarterly Interim Settlement Cost Report. This Interim Settlement Cost Report is due within 90 days from the close of a quarterly reporting period,
 - 2) Annual Settlement Cost Report. An annual cost report to reconcile the LEA's final settlement is due on or before April 1 following the reporting period.

The primary purposes of the cost report process are to:

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

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

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

(E). The Cost Reconciliation Process:

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

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

(F). The Cost Settlement Process

EXAMPLE:

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

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

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

Effective Date: 04/01/12

8. Dental Services (Clinics)

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

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

Effective Date: 04/01/12

9. Home Health Care

a. Nursing and Home Health Aide Services

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

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

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

Effective Date: 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 data base, will be based on a monthly service fee. Rates will be established by Medicaid and based on usual and customary charges.

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

Effective Date: 07/01/87

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

10. Family Planning

Effective Date: 01/01/92

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

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

Effective Date: 01/01/92

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

Effective Date: 01/01/92

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

11. Ambulance Services

Effective Date: 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.

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: 10/01/2022

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, 2023, 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, 2023, 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, 2023, 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, 2023, 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>.

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, 2023, 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 2023. 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 four State Fiscal Years, excluding State Fiscal Years 2020 and 2021, 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.

- (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, 2023 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.

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. Alternative Payment Methodology (APM) Reimbursement

Beginning October 1, 2019, FQHCs that are Alabama Coordinated Health Network (ACHN) Certified are eligible to receive an APM reimbursement in addition to the PPS rate, but only if the following statutory requirements are met. First, the APM must be agreed to by Alabama Medicaid and by each individual FQHC that participates in the program. Second, the methodology must result in a total payment (PPS plus APM) that is at least equal to the amount to which the FQHC is entitled under the Medicaid PPS.

ACHN Certified Delivering Healthcare Professionals (DHCPs) Enhanced Payment

ACHN Certified DHCPs will receive an enhanced payment for:

- iii. an initial prenatal visit in the first trimester and/or
- iv. a post-partum visit.

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 \$15 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 1, 2019 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 2019. Subsequent payments will be made on a quarterly basis.
- vi. Level One Quality Performance Payment for the period between October 1, 2019 and September 30, 2021:
 - 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 October 1, 2021 and beyond:
1. The Agency's quarterly payments beginning with the October 2021 payment will be based on actual quality measure performance as soon as the previous calendar year's performance has been calculated (anticipated date twelve months after the start of the second contract year). For example, the quarterly payments made in October 2021, January 2022, April 2022, and July 2022 will be based on the actual quality measure performance calculated for the period between January 1, 2020 and December 31, 2020.
 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 : 10/01/2020

21. Rehabilitative Services

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. $\text{Percentage} = \text{Total 'Allowed Amount'} / \text{Total 'Billed Amount'}$
 - b. $\text{Average Billed Amount} = \text{Total 'Billed Amount'} / \text{Total 'Allowed Quantity'}$
 - c. $\text{Proposed Rate} = \text{Percentage times Average Billed Amount}$
- (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.

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 comparable 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 Part A MR Deductibles SP Coinsurance
Medicaid Part B SP Deductibles SP Coinsurance
Recipients

Dual Part A MR Deductibles SP Coinsurance
Eligible
(QMB Plus) 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:

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

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