# Table of Contents

**State/Territory Name: Alabama**

**State Plan Amendment (SPA) AL-23-0014**

This file contains the following documents in the order listed:

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

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

**Financial Management Group**

April 9, 2024

Stephanie McGee Azar, Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL 36103-5624

Re: Alabama State Plan Amendment (SPA)23-0014

Dear Ms. Azar,

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19-B of your Medicaid State Plan submitted under transmittal number (TN) 23-0014, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on October 10, 2023. This amendment will allow the Alabama Medicaid Agency to apply the reimbursement basis for inpatient and outpatient hospital services for State fiscal year 2024.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2),1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. This letter is to inform you that Alabama 23-0014 is approved effective October 1, 2023. The CMS-179 and approved plan pages are enclosed.

If you have any additional questions or need further assistance, please contact Douglas Spitler at douglas.spitler@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 23 — 0014

2. STATE: AL

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2023

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 262,066,036
b. FFY 2025 $ 115,914,006

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A pages: 3A, 6H, 6I, 6I.1, 6I.2, 6I.3, 6I.4, 6I.6, 6J, and 8D

Attachment 4.19-B pages: 8.a, 8.1, 8.2, 8.3, and 8.3.b

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A pages: 3A, 6H, 6I, 6I.1, 6I.2, 6I.3, 6I.4, 6I.6, 6J, and 8D

Attachment 4.19-B pages: 8.a, 8.1, 8.2, 8.3, and 8.3.b

9. SUBJECT OF AMENDMENT
The primary purpose for this amendment is to allow the Alabama Medicaid Agency to apply the reimbursement methodology for inpatient and outpatient hospital services for State fiscal year 2024 in a manner consistent with that used in fiscal year 2023.

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Stephanie McGee Azar

13. TITLE
Commissioner

14. DATE SUBMITTED
10/10/23

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

***FOR CMS USE ONLY***

16. DATE RECEIVED
10/10/2023

17. DATE APPROVED
April 9, 2024

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

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

METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/23

(m) Access Payment: A supplemental payment by the Medicaid program to an eligible hospital for inpatient and outpatient hospital care provided to a Medicaid recipient.

(n) Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2013, through September 30, 2024, a facility, which is licensed as a hospital under the laws of the State of Alabama, provides 24-hour nursing services, and is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled.

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

(p) Privately Owned and Operated Hospital: For purposes of Medicaid base per diem, supplemental and DSH payments, a hospital in Alabama other than:

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

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

(3) A hospital created and operating under the authority of a governmental unit which has been established as a public corporation pursuant to Chapter 21 of Title 22, Chapter 51 of Title 22, or Chapter 95 of Title 11, or a hospital otherwise owned and operated by a unit of local government, Alabama Code of 1975 22-21-1.

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

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

(q) Non State Government Owned and Operated Hospital: For purposes of Medicaid base per diem payments, supplemental payments and DSH payments, a hospital in Alabama created or operating under the authority of a governmental unit which has been established as a public corporation pursuant to Ala. Code, Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned or operated by a unit of local government pursuant to Alabama Code of 1975 22-21-1.

(r) State Owned or Operated Hospital: For purposes of Medicaid base per diem payments, quarterly adjustment and DSH payments, a hospital in Alabama that is a state agency or unit of state government, including without limitation a hospital owned or operated by a state agency or a state university.

(s) Rehab Hospitals and Long Term Acute care hospitals referenced in paragraph (p)(4) and (p)(5) above are not included in UPL or reimbursed by Medicaid for base payments, access payments under section 4.19-A.

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METHOD FOR PAYMENT OF INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/23

(j) For the period October 1, 2017, through September 30, 2024, each hospital shall receive an inpatient Medicaid base (per diem) payment, in accordance with the following:

(1) Medicaid shall pay each hospital as a base (per diem) amount for state fiscal year 2024 the greater of the hospitals current per-diem as published for fiscal year 2022 or 68% of total inpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2019, divided by the total paid inpatient hospital days incurred by that hospital in state fiscal year 2019, multiplied by the inpatient hospital days incurred by each hospital during fiscal year 2024.

Effective October 1, 2018, Long Acting Reversible Contraceptives (LARCs) will be reimbursed separately from the inpatient daily per diem rate when the LARC is provided as part of the inpatient obstetrical delivery or in the outpatient setting immediately after discharge. A separate outpatient claim may be submitted by the hospital for reimbursement under the appropriate HCPCS code when the LARC is provided in the inpatient setting immediately after delivery.

(2) Base (per diem) payments for state fiscal year 2024 will not be made to any non state government owned or operated Hospital owned, state owned or operated or privately owned or operated hospital that was in operation during the hospital's fiscal year ending in 2009 that ceases to operate as a hospital, beginning on the date that the facility ceases to operate as a hospital.

(3) Quarterly access payments as outlined in paragraph (k) and (l) on pages 6I through 6J will be distributed as follows:

a. State owned and operated hospitals' inpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap, reallocate any access to ensure the state owned mental health facility does not exceed OBRA payments, reallocate $27,580,772 and $59,101,655 to be paid to rural and children hospitals, respectively, in proportion to all rural and children hospitals total upper payment limit and finally reduce any access payments to ensure a payment over billed amount is not made. All remaining access will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.

b. Non state government owned or operated hospitals' inpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap then reduce any access payments to ensure a payment over billed amount is not made and reallocate $27,580,772 and $59,101,655 to be paid to rural and children hospitals, respectively, in proportion to all rural and children hospitals total upper payment limit. All remaining access will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.

c. Privately owned and operated hospitals' inpatient access payments will be distributed first by paying free standing psychiatric hospitals per paragraph (n) on page 6J, then removing any negative Upper Payment Limit Gap, reallocating $27,580,772 and $59,101,655 to be paid to rural and children hospitals, respectively, in proportion to all rural and children hospitals total upper payment limit, and finally reduce any access payments to ensure a payment over billed amount is not made. All remaining access payments will be allocated based on the hospitals Medicaid days in relation to the total Medicaid days. During the period October 1, 2023 through September 30, 2024, Inpatient Access payments for the rate year ending September 30, 2024 to all hospitals shall be limited to an aggregate amount that when added to estimated base payments equals 160% of estimated cost of inpatient services to Medicaid beneficiaries. Any UPL Gap that is not paid to providers through access payments will be allocated to a separate pool that will be paid in a subsequent period in proportion to the hospital that generated the pool.

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(k) For the period October 1, 2023, through September 30, 2024, the amount available for inpatient hospital access payments for state owned or operated hospitals, Non state government owned or operated hospitals', and Privately owned and operated hospitals' that have Medicare payments identified in the CMS Form 2552-10 cost report ended in the rate year one year prior to the beginning of the rate year shall be calculated as follows:

(1) A Medicare per-diem shall be calculated using the CMS Form 2552-10 cost report ended in the rate year one year prior to the beginning of the rate year.

(a) Medicare Payments are obtained from the following cost report lines:

1. Acute Care Hospitals: Sum of Worksheet E Part A column 1 line 59, Worksheet E-3 Part II column 1 line 12, and Worksheet E-3 Part III column 1 line 13.
2. Critical Access Hospitals: Sum of Worksheet E-3 Part V column 1 line 19 and Worksheet E-3 Part III column 1 line 19.
3. Children's Hospitals: Worksheet E-3 Part I column 1 line 4.
4. Psychiatric Hospitals: Worksheet E-3 Part II column 1 line 12.

(b) Medicare days are obtained from the following cost report Lines:

1. Acute Care Hospitals: Sum of Worksheet S-3 Part I column 6 lines 14, 16, and 17.
2. Critical Access Hospitals: sum of Worksheet S-3 Part I column 6 lines 14, 16, and 17.
3. Children's Hospitals: sum of Worksheet S-3 Part I column 6 lines 14, 16, and 17
4. Psychiatric Hospitals: sum of Worksheet S-3 Part I column 6 lines 14, 16, and 17.

(2) The Medicare per-diem calculated in the previous step will be multiplied by the Medicaid hospital days obtained from the State's MMIS system for each hospital's discharges during the applicable cost report ended in the rate year one year prior to the beginning of the rate year for claims which would be covered during SFY 2024 to determine the amount Medicare would have paid for Medicaid services. Medicaid utilization impacted by the COVID-19 public health emergency will be adjusted to reflect estimated utilization levels in the rate year prior to the COVID-19 public health emergency.

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(3) The amount Medicare would have paid for Medicaid services will be multiplied by an increase in cost due to the CMS Market Basket Inpatient Hospital PPS ( https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData) and a separate utilization increase based on change in paid days a linear regression completed for the previous five State Fiscal Years, excluding State Fiscal Years 2020, 2021, and 2022, and the fiscal year ended during the preceding cost reporting year and preceding rate year. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.

(4) The amount determined in this step will be the Upper Payment Limit amount set forth in 42 CFR 447.272. An aggregate Upper Payment Limit amount will be established for State owned and operated hospitals, Non state government owned or operated hospitals, and Privately owned and operated hospitals'.

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(5) The Medicaid allowed amount, for claims included in paragraph (2), was obtained from the MMIS for the same period as outlined in paragraph (1) and includes the utilization adjustment described in paragraph (2). The utilization increase identified in paragraph (3) and the cost report factors in paragraph (3) was applied to the Medicaid allowed amount to standardize all hospital payments to the mid-point of the State Fiscal Year the cost reporting year ends during.

(6) The difference between Medicare Payments for Medicaid Services determined in paragraph (4) and the Medicaid payments in paragraph (5) will be the Upper Payment Limit Gap amount for State owned and operated hospitals, Non state government owned or operated hospitals', and Privately owned and operated hospitals'. The Upper Payment Limit Gap will represent the maximum amount the State shall pay for Access payments to State owned and operated hospitals.

(l) For the period October 1, 2023, through September 30, 2024, the amount available for inpatient hospital access payments for privately owned and operated hospitals and non-state government owned and operated hospitals that do not have sufficient Medicare data to calculate a Medicare per-diem UPL calculation determined from paragraph (4) shall be calculated as follows:

(1) Data from hospital's CMS Form 2552-10 cost reports that ended in the rate year one year prior to the beginning of the rate year (ex. Cost reports ending in rate year 2017 for the rate year beginning October 1, 2018) will be used to determine the upper payment limit.

(2) A routine inpatient cost to charge ratio and an inpatient ancillary cost to charge ratio are determined from each cost report by obtaining the following information from the CMS Form 2552-10 cost reports for each hospital:

(a.) Inpatient routine cost to charge ratio

(i.) Total cost will be accumulated from Worksheet B Part I Column 24 for Lines 30-43.

(ii.) Total charges will be accumulated from Worksheet C Part I Column 6 for CMS Lines 30-43.

(iii.) Total cost per paragraph (i) will be divided by total charges per paragraph (ii) to determine the inpatient routine cost to charge ratio for each hospital.

(b.) Inpatient ancillary cost to charge ratio

(i.) Total cost for each of the following centers on Worksheet B Part I is obtained: CMS Lines 50-76.99 and 90-93.99.

(ii.) Inpatient charges for each of the following cost centers on Worksheet C Part I Column 6 are obtained: CMS Lines 50-76.99 and 90-93.99.

(iii.) Total charges for each of the following cost centers on Worksheet C Part I Column 8 are obtained: CMS Line 50-76.99 and 90-93.99.

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(iv.) Inpatient charges for each CMS Line in paragraph (ii) will be divided by the total charges for each CMS Line in paragraph (iii) to determine an inpatient percentage of charges.

(v.) The total cost for each CMS Line in paragraph (i) will be multiplied by the inpatient percentage of charges for each CMS Line in paragraph (iv) to determine the inpatient cost.

(vi.) Total inpatient cost determined in paragraph (v) will be divided by total inpatient charges from paragraph (ii) to determine an inpatient ancillary cost to charge ratio.

(c.) For privately owned and operated psych hospitals that do not file a Medicare cost report, the Medicaid submitted cost report will be used as follows:

(i.) Total inpatient cost Per Medicaid Worksheet C Column 2 Line 150 and Line 156 through Line 196.

(ii.) Total inpatient charges Per Medicaid Worksheet C Column 1 Line 150 and Line 156 through Line 196.

(iii.) Total inpatient cost to charge ratio will be paragraph (i) divided by paragraph (ii).

(3) Inpatient charges will be obtained from the State's MMIS system for each hospital's discharges during the applicable cost report ended in the rate year one year prior to the beginning of the rate year for claims which would be covered during SFY 2024. The inpatient charges will be obtained at the revenue code level. Medicaid utilization impacted by the COVID-19 public health emergency will be adjusted to reflect estimated utilization levels in the rate year prior to the COVID-19 public health emergency.

(4) Inpatient charges for each hospital with revenue codes 001 through 219 will be multiplied by the inpatient routine cost to charge ratio determined in paragraph (2)(a)(iii) for each hospital to determine the inpatient routine cost.

(i.) For privately owned and operated psych hospitals that do not file a Medicare cost report, the MMIS inpatient charges will be multiplied by the cost to charge ratio in paragraph (c) to determine inpatient cost for privately owned and operated psych hospitals.

(5) Inpatient charges for each hospital with revenue codes 220 through 999 will be multiplied by the inpatient ancillary cost to charge ratio determined in paragraph (2)(b)(vi) for each hospital to determine the inpatient ancillary cost.

(6) Total inpatient Medicaid cost will be the total of paragraph (4) and (5). The total inpatient Medicaid cost will have the following amounts added:

(a.) The Medicaid cost will be increased by the Medicaid inpatient percentage of CRNA cost removed on Worksheet A-8 for each hospital. The Medicaid inpatient percentage is determined by dividing total Medicaid inpatient charges by total charges for the hospital.

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(7) The amount determined in paragraph (6) will be multiplied by an increase in cost due to the CMS Market Basket Inpatient Hospital PPS (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-actual.pdf) and a separate utilization increase based on change in paid days a linear regression completed for the previous five State Fiscal Years, excluding State Fiscal Years 2020,2021, and 2022, and the fiscal year ended during the preceding cost reporting year and preceding rate year. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.

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(10) The difference between Medicare cost for Medicaid Services determined in paragraph (8) on page 6I.5 and the Medicaid payments in paragraph (9) on page 6I.5 for the rate year will be the Upper Payment Limit Gap that will be used as the limit to the amount of Access payments outlined in paragraph (m) and (n) below.

(m) For the period October 1, 2023, through September 30, 2024, in addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible hospital, excluding free-standing psychiatric hospitals, shall receive inpatient hospital access payments each fiscal year. Inpatient hospital access payments shall include the following:

(1) An inpatient access payment to hospitals determined on a quarterly basis by the Alabama Medicaid Agency that complies with paragraph (3) below. Aggregate hospital access payments for each category of hospitals will be the amount calculated in paragraph (k)(7) for state owned or operated hospitals and the amount calculated in paragraph (l)(10) for non state government owned and operated hospitals and private hospitals. Annual amount to be paid for each State Fiscal Year will be made as indicated in paragraph (3) on page 6H.
(2) These additional inpatient hospital access payments shall be made on a quarterly basis.
(3) The inpatient hospital access payments shall not exceed the annual applicable hospital inpatient upper payment limit Gap for each category of hospitals submitted to CMS.

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(n) For the period October 1, 2023, through September 30, 2024, in addition to any other funds paid to private free-standing psychiatric hospitals for inpatient hospital services to Medicaid patients, qualifying hospitals shall receive a private free-standing psychiatric hospital access payment equal to $300 per Medicaid inpatient day paid based on the Medicaid days per the cost report ending during the State Fiscal Year 2022.

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Effective Date: 10/01/23

(f) For the period from October 1, 2021, to September 30, 2024, the Alabama Medicaid Agency shall appropriate and expend the full disproportionate share allotment to hospitals under Section 1923(f) (3) of the Social Security Act (the Act) in a manner consistent with the hospital-specific DSH limits under section 1923(g) of the Act.

(1) Payments to disproportionate share hospitals shall be made to all hospitals qualifying for disproportionate hospital payments under Section 1923(d) and 1923(b) of the Social Security Act.

(2) Medicaid shall pay qualifying non-state government and state owned disproportionate share hospitals an amount up to each hospital's allowable uncompensated care cost under the hospital specific DSH limit in Section 1923(g) of the Social Security Act as outlined in Exhibit C. State owned institutions for mental disease shall receive no more than the IMD allotment.

(3) Qualifying non-state government and state owned disproportionate share hospitals as defined on Attachment 4.19-A Page 3A shall receive an amount such that the sum of inpatient hospital payments, outpatient payments, and disproportionate share hospital cost do not exceed each hospital's DSH limit under 1923(g) of the Social Security Act. Medicaid cost for these services shall be allowable cost determined in accordance with the Medicare Principles of Reimbursement, the applicable CMS 2552 and the DSH final rule effective January 19, 2009 which states on page 77913 "(t)he treatment of inpatient and outpatient services provided to the uninsured and the underinsured…must be consistent with the definition of inpatient and/or outpatient services under the approved Medicaid State Plan."

(4) Eligible hospitals administered by the Department of Mental Health shall be paid an amount of DSH funds not to exceed the DSH IMD Allotment published annually by CMS.

(5) The disproportionate share hospital allotment remaining after disproportionate share hospital payments have been made to non-state government and state owned hospitals shall be paid to private hospitals, as defined on Attachment 4.19-A Page 3A, using their available cost in relation to total private cost. Disproportionate share hospital payments shall be paid to eligible private hospitals who do not exceed their estimated disproportionate share hospital payment limit calculated at the beginning of the State Fiscal Year.

**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: 10/01/2023

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, 2024, 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, 2024, 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, 2024, 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, 2024, 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 2024. Consistent with paragraph (1.) above, the applicable cost reporting period for each hospital will be the cost report with a fiscal year ending during the rate year one year prior to the rate year (ex. Cost reports ending in rate year 2012 would be used for rate year beginning October 1, 2013). Medicaid utilization impacted by the COVID-19 public health emergency will be adjusted to reflect estimated utilization levels in the rate year prior to the COVID-19 public health emergency.

(4.) Total Medicaid outpatient charges in Step (3) on page 8.2 are multiplied by the cost to charge ratio calculated in Step (2) on page 8.2 to determine Medicare cost of Medicaid services for each hospital's cost report year. The Medicaid cost will be increased by the Medicaid outpatient percentage of CRNA cost removed on Worksheet A-8. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges by total charges for the hospital. The Medicaid cost amount will be multiplied by an increase in cost due to the CMS Market basket Inpatient Hospital PPS (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics- Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData) and a separate utilization increase based on change in paid ICN claim counts a linear regression completed for the previous five State Fiscal Years, excluding State Fiscal Years 2020,2021, and 2022, and the fiscal year ended during the preceding cost reporting year and preceding rate year.. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.

(5.) The Medicaid cost for the State Fiscal Year being calculated will be increased by the Medicaid outpatient percentage of provider assessment for the State Fiscal Year being calculated for each privately owned and operated hospital. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges from the cost reports outlined in paragraph (1) on page 8.2 by total charges for the hospital from the cost reports outlined in paragraph (1) on page 8.2.

(6.) The difference between Medicare cost of Medicaid services determined in Step (5) on page 8.3 and the Medicaid payments in Step (6) on page 8.3.a will be the Upper Payment Limit Gap for each hospital type.

(7.) Privately owned acute care hospitals, that meet the criteria in (a) and (b) below, may be paid an enhanced payment not to exceed an amount as may be set annually by Medicaid based on amounts paid in prior years and consistent with paragraph (9) and subject to any applicable limits related to the individual hospital's billed charges under provisions of Medicare reimbursement regulations:

a. The hospital must be located in a county with a population greater than 200,000 (according to the latest U.S. census), and
b. the hospital must participate in the county's largest city's outpatient/emergency room assistance program.

The enhancement payment under this section for the fiscal year ending September 30, 2024 is zero.

(8.) Each hospital, excluding private free-standing psychiatric hospitals, may receive outpatient access payments. Additionally, qualified hospitals under paragraph (8) shall receive enhancement payments. The total amount of outpatient access payments and enhancements payments shall not exceed the aggregate hospital type Upper Payment Limit Gap set forth in paragraph (7).

a. State owned and operated hospitals' outpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap then set University of South Alabama Women and Children's at 115% of UPL. All remaining access will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.

b. Non state government owned or operated hospitals' outpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap then allocating remaining access based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.

c. Privately owned and operated hospitals' outpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap then reallocate Access necessary to cover the enhancement payments per paragraph 9. The remaining access will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.

(9.) Access payments are paid quarterly.