Table of Contents

State/Territory Name: Alabama

State Plan Amendment (SPA) #: 13-016

This file contains the following documents in the order listed:

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

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

Financial Management Group

DEC 02 2014

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

Re: Alabama State Plan Amendment 13-016

Dear Ms. Azar:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19B of your Medicaid State plan submitted under transmittal number (AL) 13-016. Effective for inpatient services and outpatient hospital services October 1, 2013, this amendment proposes to discontinue the Certified Public Expenditure (CPE) program for State and Non State governmental hospital facilities and to implement plan authority for an Upper Payment Limit (UPL) program for State and Non-State governmental hospitals. In addition, this amendment proposes to implement a fee schedule based payment methodology for hospital outpatient services with bi annual 6% increases.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of October 1, 2013. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Dicky Sanford at (334) 241-0044.

Sincerely,

//s//

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: AL-13-016

2. STATE: Alabama

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

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

4. PROPOSED EFFECTIVE DATE
October 1, 2013

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430 Subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 28,087,745
b. FFY 2015 59,515,596

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Pages 3A, 6H, 6I, 6I.1, 6I.2, 6J, 8D, 8E and Exhibit C.
Attachment 4.19-B, Pages 8.a, 8.1, 8.2, 8.3, 8.3.a, 8.3.b, and Exhibit A.
Attachment 3.1-A, Pages 1-1.xx

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

SPA 11-016

10. SUBJECT OF AMENDMENT:
The primary purpose for this amendment is to convert Medicaid inpatient and outpatient CPE program to an upper payment limit methodology for State owned hospitals and non-State government owned and operated hospitals; to increase the outpatient fee schedule by 6% from SFY 2013 amount; to change the funding mechanism which converts from CPE to IGT; and to modify the definition of outpatient hospital services.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Stephanie McGee Azar

14. TITLE: Acting Commissioner

15. DATE SUBMITTED: 12-30-13

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12-30-13

18. DATE APPROVED: 12-02-14

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10-01-13

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Timothy Hill

22. TITLE: Director

23. REMARKS:

Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance for Disproportionate Share Hospital Expenditures.

The Alabama Medicaid Agency uses the **CMS Form 2552** cost report, which was prepared based on Medicare cost reporting principles, as the basis for ensuring proper cost allocation and apportionment for services provided to Medicaid eligible beneficiaries and individuals with no source of third party insurance. Worksheets from the CMS Form 2552 cost report will be identified as appropriate in this Exhibit to ensure proper calculation of cost to be certified as public expenditures (CPE) for both inpatient and outpatient services, as defined in Attachment 3.1A, by hospitals. The Agency will use the protocol below.

Cost of the uninsured

1. Calculation of Interim Disproportionate Share Hospital (DSH) Limit: A base year will be used to calculate the cost of the uninsured and Medicaid eligible beneficiaries. The base year will be the State fiscal year with the most recent DSH audit being completed. The Interim DSH Limit for each hospital will be the estimated compensated care for inpatient and outpatient services to individuals with no source of third party insurance plus the uncompensated care (including potential surplus) for inpatient and outpatient services to Medicaid eligible individuals.

   This computation of establishing interim DSH payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

   a. Using the CMS Form 2552 cost report for the fiscal year ending during the fiscal year data being used (ex. 2010 data for 2012 payments), a cost to charge ratio will be determined at the facility level. The data sets used to calculate the cost to charge ratio are as follows:

CMS Form 2552-96	***CMS Form 2552-10***
Worksheet C Part I Column 1 line 103 less lines 34-36 (Total Cost)	Worksheet C Part I Column 1 line 202 less lines 44-46 (Total Cost)
Worksheet C Part I Column 6 line 103 less lines 34-36 (Inpatient Charges)	Worksheet C Part I Column 6 line 202 less lines 44-46 (Inpatient Charges)
Worksheet C Part I Column 7 line 103 less line 34-36 (Outpatient Charges)	Worksheet C Part I Column 7 line 202 less lines 44-46 (Outpatient Charges)
Worksheet C Part I Column 8 line 103 less line 34-36 (Total Charges)	Worksheet C Part I Column 8 line 202 less line 44-46 (Total Charges)

   The cost-to-charge ratio (CCR) was determined by dividing total costs by total charges, with the same CCR ratio used for inpatient and outpatient.

b. The inpatient and outpatient Medicaid hospital covered charges will be multiplied by the CCR to determine Medicaid cost. All payments made related to these Medicaid hospital covered charges would be used to offset the Medicaid cost to determine uncompensated Medicaid hospital cost.

c. The inpatient and outpatient hospital charges related to individuals with no source of third party coverage will be multiplied by the CCR to determine the cost of services to individuals with no source of third party insurance. Payments related to these individuals will be used to offset the cost of services to determine the uncompensated cost of services to individuals with no source of third party insurance.

d. The uncompensated care of hospital services for individuals with no source of third party insurance will be combined with the uncompensated Medicaid hospital cost to determine the uncompensated care cost. Any Medicaid hospital payments in excess of Medicaid hospital cost will be used to offset uncompensated care of services for individuals with no source of third party insurance.

e. The uncompensated care cost calculated will be trended by the hospital market basket index as published by Global Insight Health-Care Cost Review to determine the interim DSH limit for the reporting year payments being calculated by applying the Global Insight Health-Care Cost Review from the mid-point of the cost reporting fiscal year to the mid-point of the next State Fiscal Year and then from mid-point of the State fiscal year to the mid-point of the current State Fiscal Year.

2. Interim Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year: Upon completion of the State's reporting year, each hospital's interim payments paid under the calculations for disproportionate share hospital payments as outlined in paragraph f of Attachment 4.19-A will be reconciled to its CMS Form 2552 cost report as filed to the Medicare Administrative Contractor (MAC) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

This interim reconciliation will be completed within 10 months of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State.

Each hospital will supply the State with covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System and for services provided to individuals with no source of third party insurance (referred to as Non-Alabama Medicaid Fee for Service (FFS) Medicaid eligible activity).

Uncompensated cost of care for services provided to Medicaid eligible individuals shall be calculated as follows:

a. The hospital cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of Medicaid cost.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 22 lines 30-43, and 50-117 shall be included in the calculation of Medicaid cost.
Medicaid Routine Service Cost for Acute Services	Medicaid Routine Service Cost for Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 7, lines 7-13
Medicaid Routine Service Cost for Sub-Provider Services	Medicaid Routine Service Cost for Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 7, line 16-18.
Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

c. Combining the cost of Medicaid routine services, cost of Medicaid inpatient ancillary services, cost of Medicaid outpatient ancillary services, the cost of Medicaid organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid utilization of Medicaid charges divided by total charges less the payments received for CRNA services.

d. The payments received related to Medicaid services provided during the reporting period will be offset against total Medicaid cost of services to determine the Medicaid uncompensated care.

Uncompensated cost of care for hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSHA Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 23 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Individuals With No Source of Third Party Insurance Routine Service Cost for Acute Services	Individuals With No Source of Third Party Insurance Routine Service Cost for Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.
Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the uninsured utilization of uninsured charges divided by total charges to determine the total cost of services provided to individuals with no source of third party insurance.

d. The payments received during the reporting period related to accounts of individuals with no source of third party will be used as offset to total cost of services to determine the uncompensated cost of care of services provided to individuals with no source of third party insurance

The uncompensated care of hospital services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for hospital services provided to Medicaid eligible individuals to determine the uncompensated care cost. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of hospital services for individuals with no source of third party insurance.

The State will compare the interim reconciliation to initial DSH limit for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

e. Final Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS 2552 cost report as adjusted by the MAC for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

The final reconciliation will be completed by the end of the third CMS Form 64 quarter that follows the CMS Form 64 quarter where the of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State occurs.

If necessary, each hospital will supply the State with updated covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System and for services provided to individuals with no source of third party insurance. The State will also update any payment offset if necessary.

Uncompensated cost of care for services provided to Medicaid eligible individuals shall be calculated as follows:

a. The cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 23 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
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Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.
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b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

c. Combining the cost of Medicaid routine services, cost of Medicaid inpatient ancillary services, cost of Medicaid outpatient ancillary services, the cost of Medicaid organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid utilization of Medicaid charges divided by total charges less the payments received for CRNA services will represent the cost of Medicaid eligible hospital services.

d. The payments received related to Medicaid hospital services provided during the reporting period will be offset against total Medicaid cost of services to determine the Medicaid uncompensated care.

Uncompensated cost of care for hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol as follows:

CMS Form 2552-96	*CMS Form 2552-10*
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Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services
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Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition plus the uninsured portion of CRNA expense removed on Worksheet A-8 based on the uninsured utilization based on uninsured charges divided by total charges to determine the total cost of hospital services provided to individuals with no source of third party insurance.

d. The payments received during the reporting period related to accounts of individuals with no source of third party will be used as offset to total cost of services to determine the uncompensated cost of care of services provided to individuals with no source of third party insurance.

The uncompensated care of hospital services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for services provided to Medicaid eligible individuals to determine the uncompensated care cost of hospital services. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of hospital services for individuals with no source of third party insurance.

The State will compare the final reconciliation to the interim reconciliation for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

Listing of 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 OF ALABAMA

DEFINITION OF A CLAIM

Effective Date: 10/01/80

Within the guidelines of 42 CFR 447.45(b), the definition of a claim for each of the several types of covered services provided recipients through the Alabama Medicaid Program is included in this attachment. In each of the definitions the term "claim form" is used. This does not limit the submission of claims to hardcopy. Submission of claims in any Medicaid prior approved method is acceptable. This could include magnetic tape, diskettes, or continuous form of billing.

Effective Date: 10/01/14

1. Inpatient Hospital Claim

An inpatient Hospital Claim is a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim for each in-hospital period in a calendar year. Except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or additional inpatient days that have been authorized for deliveries, or children who have been referred for treatment as the result of an EPSDT screening. For rate year beginning October 1, 2014, the 16 day reimbursement limit will no longer be effective.

Effective Date: 10/01/11

2. Outpatient Hospital Claim

An Outpatient Hospital Claim is a bill for all services except physician charges provided a recipient by a provider and submitted for payment on an approved Medicaid claim for each visit, except for chemotherapy, physical or occupational, and radiation therapy which may be span billed for services rendered during a calendar month.

Effective Date: 07/01/87

3. Rural Health Clinic Claim

A Rural Health Clinic Claim is a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim form for each encounter.

Listing of Inpatient Access Payments and Disproportionate Share Hospital Payments

Inpatient access payments and DSH payments distributed to individual hospitals include consideration of the following factors; Hospital Cost, OBRA limits, hospital charges, overall UPL GAP by hospital category, and other special circumstances. The payments for each hospital are noted below for rate year 2014.

Inpatient Access Payments for the State Fiscal Year Ended September 30, 2014

State Owned and Operated Hospitals

Facility	Inpatient Access Payments
UNIVERSITY OF ALABAMA	59,707,266
USA CHILDRENS & WOMENS HOSPITAL	8,932,741
USA MEDICAL CTR HOSP	24,344,371
Total State Owned and Operated Hospitals	92,984,378

Non-State Government Owned and Operated Hospitals

Facility	Inpatient Access Payments
ATHENS LIMESTONE HOSP	2,790,129
GULF HEALTH HOSPITALS DBA THOMAS HOSPITAL	322,014
BAPTIST MEDICAL CENTER EAST	9,176,040
BAPTIST MEDICAL CTR SOUTH	24,437,969
BIBB MEDICAL CENTER HOSPITAL	1,217,948
BRYAN W WHITFIELD MEMORIAL H	1,946,778
CALLAHAN EYE FOUNDATION HOSPITAL	4,402
COOSA VALLEY MEDICAL CENTER	1,810,995
CULLMAN REG MEDICAL CENTER	2,401,431
D.W. MCMILLAN MEMORIAL HOSPITAL	69,431
DALE MEDICAL CENTER	341,132
DCH REGIONAL MEDICAL CENTER	8,382,898
DECATUR GENERAL HOSPITAL	2,490,010
EAST AL MEDICAL CENTER	4,469,272

Facility	Inpatient Access Payments
ECACH INC/ATMORE COMMUNITY H	219,480
GREENE COUNTY HOSPITAL	1,145,673
GROVE HILL MEMORIAL HOSPITAL	915,665
HALE COUNTY HOSPITAL	105,630
HELEN KELLER HOSPITAL	1,905,966
HIGHLANDS MEDICAL CENTER	694,160
HILL HOSPITAL OF SUMTER COUN	654,699
HUNTSVILLE HOSPITAL	9,964,993
JPAUL JONES HOSPITAL	1,379,061
LAWRENCE MEDICAL CENTER	251,433
MARSHALL MEDICAL CENTER SOUT	2,640,614
MEDICAL CENTER BARBOUR	1,830,240
MEDICAL WEST	4,016,017
MONROE COUTNY HOSPITAL	936,472
NORTH BALDWIN INFIRMARY	601,205
NORTHEAST AL REGIONAL MED CT	4,378,541
PARKWAY MEDICAL CENTER	2,416,292
PICKENS COUNTY MEDICAL CTR	711,832
PRATTVILLE BAPTIST HOSPITAL	539,682
RED BAY HOSPITAL	77,885
SOUTHEAST ALABMAM MED CTR	4,661,216
TROY REGIONAL MEDICAL CENTER	1,626,880
WASHINGTON COUTNY HOSPITAL	2,490
WEDOWEE HOSPITAL	183,136
WIREGRASS MEDICAL CENTER	547,613
Total Non-State Government Owned and Operated Hospitals	102,267,324

Privately Owned and Operated Hospitals

Facility	Inpatient Access Payments
ANDALUSIA REGIONAL HOSPITAL	3,990,633
BULLOCK COUTNY HOSPITAL	1,689,107
CHOCTAW COMMUNITY HOSPITAL	394,702
CITIZENS BAPTIST MEDICAL CTR	7,913,736
COMMUNITY HOSPITAL	2,391,836
EVERGREEN MEDICAL CENTER	1,436,994
FLORALA MEMORIAL HOSPITAL	86,576
FLOWERS HOSPITAL	11,643,691
GEORGIANA HOSPTIAL	725,321
HEALTHSOUTHLAKESHORE HOSPITAL	76,319
JACK HUGHSTON MEMORIAL HOSPITAL	1,036,368
JACKSON HOSPITAL & CLINIC	13,106,429
LAKE MARTIN COMMUNITY HOSPITAL	766,445
LV STABLER MEMORIAL HOSPITAL	1,153,425
MOBILE INFIRMARY	26,587,178
NORTHWEST MEDICAL CENTER	2,655,614
RIVERVIEW REGIONAL MED CTR	9,481,887
RUSSELL HOSPITAL	5,580,241
SHOALS HOSPITAL	2,484,355
SPRINGHILL MEM HOSP	4,327,767
ST VINCENTS EAST	11,614,723
THE CHILDRENS HOSPITAL OF ALABAMA	84,970,068
TRINITY MEDICAL CENTER	12,015,100
WALKER BAPTIST MEDICAL CENTE	11,766,024
PROFESSIONAL RESOURCES MANAGEMENT PSYCHIATRIC SERV **X**	1,265,690
LAUREL OAKS BEHAVIORAL HEALTH CEN **X**	1,404,023
MOUNTAIN VIEW HOSPITAL **X**	1,080,702
HILL CREST BEHAVIORAL HLTH S **X**	1,924,132
BAYPOINTE BEHAVIORAL HEALTH **X**	975,772
Total Privately Owned and Operated Hospitals	224,544,858

X - Privately owned and operated psychiatric hospitals

Privately Owned or Operated Disproportionate Share Hospitals

Facility	DSH Payments
BAPTIST MED CENTER – PRINCET	17,584,820
BROOKWOOD MEDICAL CENTER	9,638,674
CHEROKEE MEDICAL CENTER	1,781,512
CRENSHAW COMMUNITY HOSPITAL	1,678,193
CRESTWOOD MEDICAL CENTER	6,955,069
DEKALB REGIONAL MEDICAL CENTER	5,122,720
ELIZA COFFEE MEMORIAL HOSPIT	13,554,240
ELMORE COMMUNITY HOSPITAL	815,865
FLORALA MEMORIAL HOSPITAL	220,398
GADSDEN REGIONAL MEDICAL CTR	13,738,710
GEORGE H LANIER MEMORIAL HOS	3,050,666
JACKSON MEDICAL CENTER	1,626,969
LAKELAND COMMUNITY HOSPITAL	2,250,346
MARION REGIONALMEDICAL CENTE	1,434,038
MIZELL MEMORIAL HOSPITAL	1,611,782
PROVIDENCE HOSPITAL	13,405,106
QHG OF ENTERPRISE INC	4,862,051
RUSSELLVILLE HOSPITAL	6,424,464
SHELBY BAPTIST MEDICAL CENTE	14,810,456
SOUTH BALDWIN REGIONAL MED C	5,761,895
SPRINGHILL MEM HOSP	1,717,510
ST VINCENTS BLOUNT	2,581,742
ST VINCENTS EAST	739,894
ST VINCENTS HOSPITAL	9,216,258
ST VINCENTS ST CLAIR	2,121,849
STRINGFELLOW MEM HOSP	4,811,552
TRINITY MEDICAL CENTER	785,561
VAUGHAN REG MED CTR PARKWAY CAMPU	9,461,712

NOTE: State owned and operated hospitals and non-State government owned and operated hospitals initial DSH payments will be determined with the CPE estimate in Exhibit C of this attachment and final payments will be determined through the DSH audit process and the CPE reconciliations in Exhibit C of this attachment.

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

METHOD FOR PAYMENT INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/13

(f) For the period from October 1, 2013, to September 30, 2016, 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 equal 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 same disproportionate share hospital payments the institutions received in state fiscal year 2010.

(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 the certified public expenditure related to 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. 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. For the State Fiscal Year Ended September 30, 2012, the Children's Hospital of Alabama shall receive a DSH payment in the sum to not exceed $1. The remaining privately owned hospitals shall be paid an amount based upon each hospital's eligible uncompensated care costs under the hospital specific DSH limit in Section 1923(g) of the Social Security Act during the State Fiscal Year 2007, divided by the total eligible uncompensated care costs for all eligible privately owned DSH Hospitals (excluding the Children's Hospital of Alabama) during State Fiscal Year 2007.

For the State Fiscal Year beginning October 1, 2012, the Children's Hospital of Alabama and Jackson Hospital and Clinics shall receive a DSH payment in the sum to not exceed $1.50 for each day incurred for individuals with no third party insurance during the State Fiscal Year 2007. The remaining privately owned hospitals shall be paid an amount based upon each hospital's eligible uncompensated care costs under the hospital specific DSH limit in Section 1923(g) of the Social Security Act for the State Fiscal Year. The amount paid to each hospital will be determined by the Alabama Medicaid Agency which will distribute a schedule to the hospitals prior to payment.

For the State Fiscal Year beginning October 1, 2014, disproportionate share hospital payments shall be paid to eligible private hospitals who do not exceed their estimated disproportionate share hospital payment limit calculated at the beginning of the State Fiscal Year.

(6) An initial disproportionate share hospital payment to each hospital shall be made during the first month of the state fiscal year. Additional disproportionate share hospital payments may be made during the fiscal year based on analysis of payments during the fiscal year and changes in Federal allocations. Payments to privately owned and operated hospitals will be reported in Exhibit D of this attachment.

(7) As required by Section 1923(j) of the Social Security Act related to auditing and reporting of DSH hospital payments, Alabama Medicaid will implement procedures to comply with DSH Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Beginning with the audit of the Medicaid State Plan Rate Year ended September 30, 2011, the definition of individuals who have no health insurance (or other source of third party coverage) will be based on the definition published by CMS at the date of the disproportionate share hospital payment audit.

Any reconciliation of the Certified Public Expenditures for State owned and operated hospitals or non-State owned and operated hospitals outlined in Attachment 4.19-A Exhibit C for uncompensated cost of care for services provided to individuals with no source of third party insurance that shifts the amount certified for such cost by a hospital to another hospital will be considered a redistribution of DSH payments.

Any reconciliations of the CPE where the State must return the Federal Share of the Uncompensated cost of care for services provide to individuals with no source of third party insurance to the Federal Government will constitute a re-payment of DSH monies for State owned and operated hospitals or non-State owned and operated hospitals that exceeded their DSH limit and contributed to the repayment of funds under the CPE reconciliation.

The Medicaid Agency will recoup funds from any privately owned or operated hospital that exceeded its hospital specific DSH limit as a result of audits or other corrections and shall redistribute to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit in the following manner:

For Medicaid State Plan Rate Years Ended September 30, 2011 through September 30, 2013:

(a) Funds shall be redistributed from a hospital to other private hospitals with common ownership;

(b) Funds shall be redistributed to the private hospital with the highest Medicaid Inpatient Utilization Rate (MIUR). Any remaining funds available for redistribution shall be redistributed to other private hospitals in the order of MIUR from highest to lowest.

For Medicaid State Plan Rate Years ending September 30, 2014 through September 30, 2016:

(a) The amount of the DSH payment made to the hospital will be recouped by the Alabama Medicaid Agency to the extent necessary to reduce the DSH payment to an allowable amount.

(b) Amounts recouped from privately owned and operated hospitals with payments in excess of the audited hospital specific DSH limit will be placed into a redistribution pool. Redistribution will be made to remaining privately owned and operated hospitals that do not exceed their hospital specific DSH limit. The allocation will be made based on these remaining hospitals available uncompensated care. No hospital shall exceed its hospital specific DSH limit after redistribution.

State/Territory: Alabama

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: /X/ No limitations /__/ With limitations* **

2.a. Outpatient hospital services.

   Provided: /X/ No limitations /_/ With limitations* **

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic. (Which are otherwise included in the State Plan). ##

   /X/ Provided: /_/ No limitations /X/ With limitations* **

   /_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: /_/ No limitations /X/ With limitations* **

d. This item deleted as per HCFA-PITN-MCD-4-92

3. Other laboratory and x-ray services.

   Provided: /_/ No limitations /X/ With limitations* **

##Via HCFA-PITN-MCD-4-02
#Limitations are the same as defined in 2.c above.

**Additional medically necessary services beyond limitations are covered for children under 21 years of age referred through the E.P.S.D.T. Program.

*Description provided on attachment.

Limitation of Services

1. **Inpatient Hospital Services other than those provided in an Institution for Mental Diseases.**

Additional medically necessary services beyond limitations are covered for children under 21 years of age that are eligible for E.P.S.D.T. services.

Covered inpatient hospital services are inclusive of services performed by hospital based Certified Registered Nurse Anesthetists (CRNAs).

Inpatient Hospital services are provided without limitations and in accordance with 42 CFR 440.10.

Limitation of Services

2.a. **Outpatient Hospital Services**

Additional medically necessary services beyond limitations are covered for children under 21 years of age that are eligible for E.P.S.D.T. services

Covered outpatient hospital services are inclusive of services performed by hospital based Certified Registered Nurse Anesthetists (CRNAs).

Outpatient hospital services are provided in accordance with 42 CFR 440.20.

Limitation of Services