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State/Territory Name: Alabama

State Plan Amendment (SPA) #:14-0012

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

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

Financial Management Group

June 24, 2015

Ms. Stephanie Azar
Acting Commissioner
Alabama Medicaid Agency
P.O. BOX 5624
Montgomery, Alabama 36103-5624

RE: State Plan Amendment (SPA) 14-012

Dear Ms. Azar:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 14-012. Effective October 1, 2014 this amendment proposes to remove the certified public expenditure (CPE) program from hospital base payments and to implement an upper payment limit (UPL) program for state owned and non-state government owned and operated hospitals.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with the applicable requirements and therefore have approved them with an effective date of October 1, 2014. We are enclosing the CMS 179 and the amended approved pages

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of October 1, 2014. We are enclosing the CMS-179 and the amended approved plan pages.

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

Sincerely,

//s//

Timothy Hill
Director

Enclosures

Cc:
Tim Weidler, NIRT
Stanley Fields, ROIV NIRT
Anna Dubois, ROIV NIRT
Charlie Arnold, ROIV
Mary Holly, ROIV
Joyce Wilkerson, ROIV
Joe Raymundo, ROIV

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-14-012

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, 2014

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 2015 $29,662,056
b. FFY 2016 $51,510,095

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attach 4.19-A, pages 6I, 6I.1, 6I.2, 6I.3, 6I.5, 6I.6, 6J, 6J.1, and 8E
Attachment 4.19-B pages 8.2, 8.3, 8.3.a.1, and 8.3.b
Attachment 4.19-B Exhibit A pages 5-8
Attachment 4.19-A Exhibit D pages 5-10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attach 4.19-A, pages 6I, 6I.1, 6I.2, 6I.3, 6I.5, 6I.6, 6J, 6J.1, and 8E
Attachment 4.19-B pages 8.2, 8.3, 8.3.a.1, and 8.3.b
NEW
NEW

10. SUBJECT OF AMENDMENT:
The primary purpose for this amendment is to remove limits on certain hospital services and to change the funding methodology for public hospital disproportionate share hospital payments.

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:

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:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: Approved with following changes as authorized by the state agency:

Block # 8 changed to read: Attachment 6h,61,61.1,61.2,61.4,61.5,61.6,6j,6j.1,6j.2,8d, and 8e: Attachment 4.19-B pages 8.2,8.3,8.3.a.1, 8.3.a and 8.3.b; Remove Attachment 4.19-B Exhibit A pages 5-8 and Attachment 4.19-A Exhibit D pages-5-10 from the 179.
Block #9 Changed to read: Attachment 6h,61,61.1,61.2,61.4,61.5,61.6,6j,6j.1,6j.2,8d, and 8e: Attachment 4.19-B pages 8.2,8.3,8.3.a.1, 8.3.a and 8.3.b.

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Effective Date: 10/01/13

(j) For the period October 1, 2013, through September 30, 2016, 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 years 2014 and 2016 the total inpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2007, divided by the total paid inpatient hospital days incurred by that hospital in state fiscal year 2007, multiplied by the inpatient hospital days incurred by each hospital during fiscal years, 2014 and 2016.

(2) Base (per diem) payments for state fiscal years 2014 and 2016 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) Base (per diem) payments will be reviewed on a quarterly basis to ensure that hospitals are not paid more than the 16 day reimbursement limit, per beneficiary, 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 who have been referred for treatment as the result of an EPSDT screening. Adjustments will be made to hospitals' interim payments to reflect the results of the reconciliation. Hospitals which are privately owned or operated will be reimbursed on the basis of a maximum sixteen day annual beneficiary limit, subject to a maximum reimbursement, equivalent to the current per diem amount multiplied times the covered days (limited to the 16 day annual beneficiary limit).

For dates of service on or after October 1, 2014, the 16 day reimbursement limit will no longer be effective.

(4) Quarterly access payments as outlined in paragraph (k) and (l) on pages 6I through 6I.5 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 access to set University of South Alabama Women and Children's at 115% of UPL, 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. 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 $177 per 2012 Medicaid day per paragraph n on page 6J, then removing any negative Upper Payment Limit Gap, then paying non-qualifying DSH hospitals a per day rate per paragraph (m)(2) of page 6I.6, 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.

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(k) For the period October 1, 2014, through September 30, 2016, the amount available for inpatient hospital access payments for state owned or operated hospitals 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 2012 for the rate year beginning October 1, 2013) will be used to determine the upper payment limit.

(2) A Medicare payment to charge ratio was determined from each cost report by obtaining the following information from the CMS Form 2552-10 cost reports for each hospital:

(a) Medicare Payments were obtained from the following CMS Lines:

1. Acute Care Services: Sum of Worksheet E Part A Lines 59, 68, 69, and 70.
2. Psych Hospitals: Sum of Worksheet E-3 Part II Lines 16, 27, 28, 29, and 30.
3. Children's Hospitals: Sum of Worksheet E-3 Part I 4, 15, and 17.
4. Critical Access Hospitals: Sum of Worksheet E-3 Part V Lines 5, 6, and 18.
5. Sub-provider Psych units: Sum of Worksheet E-3 Part II Lines 16, 27, 28, 29 and 30.
6. Sub-provider Rehab units: Sum of Worksheet E-3 Part III Lines 17, 28, 29, 30, and 31.

(b) Medicare Charges were obtained from the following CMS Lines:

1. Acute Care Services: Sum of Worksheet D-3 Column 2 Lines 30-35, 43 and 200.
2. Psych Hospitals: Sum of Worksheet D-3 Column 2 Lines 40 and 200.
3. Children's Hospitals: Sum of Worksheet D-3 Column 2 Lines 30-35, 43 and 200.
4. Critical Access Hospitals: Sum of Worksheet D-3 Column 2 Lines 30-35, 43 and 200.
5. Sub-provider Psych units: Worksheet D-3 Column 2 Line 200 plus Worksheet D-1 Line 28 times the Medicaid utilization for the applicable sub-provider (Days per Worksheet S-3 Part I Line 17 Column 7 ÷ Worksheet S-3 Part I Line 17 Column 8).
6. Sub-provider Rehab units: Worksheet D-3 Column 2 Line 200 plus Worksheet D-1 Line 28 times the Medicaid utilization for the applicable sub-provider (Days per Worksheet S-3 Part I Line 17 Column 7 ÷ Worksheet S-3 Part I Line 17 Column 8).
7. Medicare organ acquisition charges (revenue code 081X Organ Acquisition) from Medicare Provider Statistical & Reimbursement (PS&R) Report obtained from provider.
8. Any additional Medicare charges related to organ acquisition billed to the Medicare Administrative Contractor, or otherwise.
9. Any additional charges related to denied encounter charges.

(3) The payment to charge ratio calculated in Step (2) will be multiplied by the Medicaid hospital charges 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 2014 through SFY 2016 to determine the amount Medicare would have paid for Medicaid services.

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(4) The amount determined in Step (3) 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 four State Fiscal Years and the fiscal year ended during the preceding cost reporting year and preceding rate year.

(5) 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.

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(6) The Medicaid allowed amount, for claims included in Step (3), was obtained from the MMIS for cost reporting periods ending in the rate year one prior to the beginning of the rate year. The utilization increase identified in Step (4) and the cost report factors in Step (4) 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. The standardized Medicaid payments for State Fiscal Year ending in the cost reporting year were multiplied by the utilization increase and adjustment factor amount in Step (5) to determine the Medicaid payments for rate year and the preceding rate year.

(7) The difference between Medicare Payments for Medicaid Services determined in Step (5) and the Medicaid payments in Step (6) will be the Upper Payment Limit Gap amount for State 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, 2014, through September 30, 2016, the amount available for inpatient hospital access payments for privately owned and operated hospitals and non-state government owned and operated hospitals shall be calculated, excluding the Children's Hospital of Alabama for the rate years beginning October 1, 2013 and October 1, 2014 which will be detailed in paragraph (o) 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 2012 for the rate year beginning October 1, 2013) 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 2014 through SFY 2016. The inpatient charges will be obtained at the revenue code level.

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

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

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

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

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

(b.) The Medicaid cost will be increased by the Medicaid inpatient percentage of RCE Disallowance cost from Worksheet C Part I Column 4 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 four State Fiscal Years and the fiscal year ended during the preceding cost reporting year and preceding rate year. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.

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(8) The Medicaid cost will be increased by the Medicaid inpatient percentage of the provider assessment paid by each hospital for the State Fiscal Year being calculated. The Medicaid inpatient percentage is determined by dividing total Medicaid inpatient charges from the cost report identified in paragraph (1) by total charges for the hospital from the cost report identified in paragraph (1).

Due to the Children's Hospital of Alabama's Medicare population being dramatically different from other acute hospitals in the State of Alabama, the Upper Payment Limit for this hospital shall be calculated separately and added to the aggregate amount for private owned and operated hospitals as outlined in this paragraph.

The cost calculated in this paragraph and the applicable amount from paragraph (o)(7) will be the Upper Payment Limit amount set forth in 42 CFR 447.272 for privately owned and operated hospitals. An aggregate Upper Payment Limit amount will be established for each of the following hospital types: Privately owned and operated hospitals and Non-state governmental owned and operated hospitals.

(9) The Medicaid allowed amount for claims included in paragraph (3) was obtained from the MMIS to constitute the Medicaid payments for cost reporting periods ending in the rate year one year prior to the beginning of the rate year. The utilization increase identified in paragraph (7) and the cost report factors in paragraph (7) was applied to the Medicaid allowed amount to standardize all hospital payments to the mid-point of the State Fiscal Year including the ending date of the cost reporting year. The standardized Medicaid payments for State Fiscal Year ending in the cost reporting year were multiplied by the utilization increase amount and adjustment factor in paragraph (8) to determine the Medicaid payments for the rate year and the preceding rate year.

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(10) The difference between Medicare cost for Medicaid Services determined in paragraph (8) on page 6K and the Medicaid payments in paragraph (9) on page 6K for the rate year plus the amount determined in paragraph (o)(11) 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, 2014, through September 30, 2016, 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 (4) below. Aggregate hospital access payments for each category of hospitals will be the amount calculated in paragraph (k)(7) for non state government owned and operated hospitals and state owned or operated hospitals and the amount calculated in paragraph (l)(10). Annual amount to be paid for each State Fiscal Year will be made as indicated in paragraph (4) on page 6H.
(2) A payment for private hospitals that do not qualify for disproportionate share payments, calculated as follows:
    (a.) For hospitals with uninsured uncompensated care costs greater than $800,000 in state fiscal year 2007, a payment equal to $400 per Medicaid inpatient day.
    (b.) For hospitals with uninsured uncompensated care costs less than $800,000 in state fiscal year 2007, a payment equal to $100 per Medicaid inpatient day.
(3) These additional inpatient hospital access payments shall be made on a quarterly basis.
(4) 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, 2014, through September 30, 2016, 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 $177 per Medicaid inpatient day paid based on the Medicaid days per the cost report ending during the State Fiscal Year 2012.

(o) For the rate year beginning October 1, 2013 and October 1, 2014 due to the Children's Hospital of Alabama's Medicare population being dramatically different from other acute hospitals in the State of Alabama as well as undergoing a recent major expansion opening in late 2012 impacting utilization and cost, the Upper Payment Limit for this hospital shall be calculated separately and added to the aggregate amount for private owned and operated hospitals as outlined in paragraph (o) below. Children's Hospital of Alabama's upper payment limit will be calculated using a cost-basis, inpatient routine and inpatient ancillary cost to charge ratio based on the above periods using Medicare Cost Report principles.

(1) For the rate year beginning October 1, 2013, Children's Hospital will prepare a cost report meeting the requirements of the CMS Form 2552-10 for the period of October 1, 2012 through June 30, 2013. For the rate year beginning October 1, 2014, Children's Hospital will use the December 31, 2013 cost report filing for the calculation of 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 C 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 cost 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 Line 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.

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.

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(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 the 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.

(3) Determination of Medicaid Inpatient Charges

(a.) For rate year beginning October 1, 2013, MMIS claims will be obtained for discharges occurring between October 1, 2012 through June 30, 2013. For the rate year beginning October 1, 2014, MMIS claims will be obtained for discharges occurring between January 1, 2013 and December 31, 2013.

(b.) For the rate year beginning October 1, 2013, the MMIS charges will be multiplied by a factor of 1.33 to annualize the payments for an entire fiscal year and account for changes in the charge structure of the hospital.

(c.) Documentation will be submitted by the hospital for charges that were reduced on Medicaid claims from the standard charges of the hospital (ex. Drug claims with billed charges stated at cost versus standard billing rate of the hospital).

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

(4) Inpatient charges for each hospital with revenue codes 001 through 214 will be multiplied by the inpatient routine cost to charge ratio determined in paragraph (2)(a)(iii) for the hospital to determine the inpatient routine cost.

(5) Inpatient charges for each hospital with revenue codes 219 through 999 will be multiplied by the inpatient ancillary cost to charge ratio determined in paragraph (2)(b)(vi) for the 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.

(b.) The Medicaid cost will be increased by the Medicaid inpatient percentage of RCE Disallowance cost from Worksheet C Part I Column 4 for each hospital. The Medicaid inpatient percentage is determined by dividing total Medicaid inpatient charges by total charges for the hospital.

(7) The annualized Medicaid inpatient cost in paragraph (6) will be multiplied by a factor calculated as the product of the following:

(a.) Rate year beginning October 1, 2013

(i.) The 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) for FFY 2014.

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(ii.) The increase percentage as outlined in paragraph (l)(7) on page 6I.4.
(iii.) An adjustment factor of 1 to bring the cost to the mid-point of SFY 2014.

(b.) Rate year beginning October 1, 2014

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

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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, 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. 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 made as indicated in paragraph (5) on page 8D.

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

Beginning with the audit of the Medicaid State Plan Rate Year ended September 30, 2011, the definition of individuals who have no health insurance (or other source of third party coverage) will be based on the definition published in the December 3, 2014, Federal Register, with an effective date of December 31, 2014.

Any reconciliation of the Certified Public Expenditures for State owned and operated hospitals or non-State government 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 government 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:

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 as follows: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx

Certified emergency room visits must be properly documented by the attending physician 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.

c. Upper Payment Limit

For the period from October 1, 2013, through September 30, 2016, 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 d. below, shall receive outpatient hospital access payments each state fiscal year. The outpatient hospital access payment shall be calculated as follows:

Due to the Children's Hospital of Alabama's Medicare population being dramatically different from other acute hospitals in the State of Alabama, the Upper Payment Limit for this hospital shall be calculated separately and added to the aggregate amount for private owned and operated hospitals as outlined in paragraph (7) below.(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. Children's Hospital of Alabama will be calculated separately for the rate year beginning October 1, 2013 and October 1, 2014, reference paragraph (7).

(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.

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.

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.

d. Outpatient charges for each CMS Line in paragraph b. will be divided by the total charges for each CMS Line in paragraph c. to determine an outpatient percentage of charges.

e. The total cost for each CMS Line in paragraph a. will be multiplied by the outpatient percentage of charges for each CMS Line in paragraph d. to determine the outpatient cost.

f. Total outpatient cost determined in paragraph e. Will be divided by total outpatient charges from paragraph b. to determine an outpatient ancillary cost to charge ratio.

(3.) Total Medicaid hospital outpatient covered charges were obtained from the Alabama Medicaid MMIS system for claims incurred for services for each hospitals cost reporting period which meet the definition of a paid claim for SFY 2014 through SFY 2016. 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.) Additionally, documentation will be submitted by hospitals for charges that were reduced on Medicaid claims from the standard charges of the hospital related to 340B pricing of claims that the Alabama Medicaid Agency required to be billed at the cost of drugs versus the hospital's standard charge. The Alabama Medicaid Agency changed this billing requirement on October 1, 2012.

(4.) Total Medicaid outpatient charges in Step (3) are multiplied by the cost to charge ratio calculated in Step (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 and RCE Disallowance cost from Worksheet C Part I Column 4. 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 (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 ICN claim counts between the State Fiscal Year ended during the rate year used for cost reports and the preceding State Fiscal Year for outpatient hospitals in Alabama. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.

(5.) The Medicaid cost for the State Fiscal Year being calculated will be increased by the Medicaid outpatient percentage of provider assessment for the State Fiscal Year being calculated for each privately owned and operated hospital. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges from the cost reports outlined in paragraph (2) by total charges for the hospital from the cost reports outlined in paragraph (2).

(7.) For the rate year beginning October 1, 2013, and for the rate year beginning October 1, 2014, Children's Hospitals of Alabama's upper payment limit will be calculated as follow:

a. For the rate year beginning October 1, 2013, Children's Hospital will prepare a cost report meeting the requirements of the CMS Form 2552-10 for the period of October 1, 2012 through June 30, 2013. For the rate year beginning October 1, 2014, Children's Hospital will use the December 31, 2013 cost report filing.

b. 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.

c. 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.

d. 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.

e. Outpatient charges for each CMS Line in paragraph c. will be divided by the total charges for each CMS Line in paragraph d. to determine an outpatient percentage of charges.

f. The total cost for each CMS Line in paragraph b. will be multiplied by the outpatient percentage of charges for each CMS Line in paragraph e. to determine the outpatient cost.

g. Total outpatient cost determined in paragraph f. will be divided by total outpatient charges from paragraph c. to determine an outpatient ancillary cost to charge ratio.

h. Total Medicaid outpatient charges will be determined as follows:

   i. For the rate year beginning October 1, 2013, MMIS claims will be obtained for dates of services occurring between October 1, 2012 through June 30, 2013.

   ii. For the rate year beginning October 1, 2014, MMIS claims will be obtained for dates of services occurring between January 1, 2013 through December 31, 2013.

   iii. For the rate year beginning October 1, 2013, MMIS claims will be annualized for a full year by multiplying the Medicaid charges per the MMIS by 1.33 to account for a change in the charge rates for Children's Hospital during the period.

i. The allowable charges in paragraph h. will be multiplied by the cost to charge ratio in paragraph g to determine the Medicaid outpatient cost. The Medicaid outpatient cost will be increased by the following:

   i. 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.

   ii. The Medicaid cost will be increased by the Medicaid outpatient percentage of RCE hospital related administration component of the RCE Disallowance cost from Worksheet C Part I Column 4. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges by total charges for the hospital.

j. The annualized Medicaid outpatient cost in paragraph i will be multiplied by a factor calculated as follows:

i. For rate year beginning October 1, 2013

1. The increase in cost due to the CMS Market basket outpatient Hospital PPS (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-actual.pdf) for FFY 2014.
2. The increase percentage as outlined in paragraph (5).
3. An adjustment factor of 1 to bring the cost to the mid-point of SFY 2014.

ii. For rate year beginning October 1, 2014

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

k. The Medicaid cost will also be increased by the Medicaid outpatient percentage of provider assessment paid for the State Fiscal Year being calculated. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges for the cost report identified in paragraph (7)c by the total charges for the hospital for the cost report identified in paragraph (7)d.

l. The Medicaid payments will be determined as follows:

i. For the rate year beginning October 1, 2013, the Medicaid payments from the MMIS claims information for dates of service occurring between October 1,.2012 and June 30, 2013

ii. For the rate year beginning October 1, 2014, the Medicaid payments from the MMIS claims information for dates of services occurring between January 1, 2013 and December 31, 2013.

(8) The difference between Medicare cost of Medicaid services determined in Step (5) and the Medicaid payments in Step (6) plus the amount determined in paragraph (7)(n) will be the Upper Payment Limit Gap for each hospital type.

(9) Privately owned acute care hospitals, that meet the criteria in (a) and (b) below, shall 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 (10) 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.

(10) Each hospital, excluding private free-standing psychiatric hospitals, may receive outpatient access payments. Additionally, qualified hospitals under paragraph (9) 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 (8).

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.

(11) Access payments are paid quarterly.