

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

Payment for Medical Care and Services, Excluding  
Inpatient Hospitals and Long Term Care Services

A description of the policy and methods to be used in establishing payment rates for each type of service, except for inpatient hospital and long term care services, listed in Section 1905(a) of the Social Security Act and included in the Alabama Medical Assistance Program, is set forth in this attachment. Payment methodology for inpatient hospital services is covered in Attachment 4.19-A. Payment for long-term care services is covered in Attachment 4.19-D.

1. Rural Health Clinic Services and Other Ambulatory Services  
Furnished by a Rural Health Clinic

**Effective Date: 01/01/01**

- a. The Medicaid Prospective Payment System (PPS) for Rural Health Clinics (RHCs) was enacted into law under Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Until the final methodology approved by HCFA is implemented, the Alabama Medicaid Agency will reimburse in the interim based on the provisions contained in our State Plan as of December 31, 2000.

In the first phase of the PPS (January 1, 2001, through September 30, 2001), Alabama Medicaid Agency will pay RHCs 100% of the average of their reasonable costs of providing Medicaid covered services by calculating a per visit rate, computed from the RHC cost reports, for FY1999 and FY2000 separately, then add those rates together and divide by two. This rate will be adjusted to take into account any increase (or decrease) in the scope of services furnished during FY 2001 by the RHC. When our new system is approved by HCFA, in place, and tested, all claims paid under the old payment methodology during calendar year 2001 will be reversed and will be paid under PPS.

The Alabama Medicaid Agency fiscal year is from October 1<sup>st</sup> through September 30<sup>th</sup>. Beginning in FY 2002, and for each fiscal year thereafter, each RHC is entitled to the payment amount (on a per visit basis) to which the RHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the RHC during that fiscal year.

A new RHC provider or a provider who constructs, leases, or purchases a facility, or has a Medicaid approved change in the scope of services, can request reimbursement based on an operating budget, subject to the ceiling established under this rule. After the actual cost report is received and desk reviewed for the budget period, an actual encounter rate will be determined. In this event, the RHC may be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. This difference may be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference. After the initial year, payment shall be set using the MEI methods used for other RHCs. A RHC that has a change of ownership can retain the previous owner's encounter rate if desired.

2. Other Laboratory and X-Ray Services

**Effective Date: 04/01/83**

- a. Payment to laboratories and x-ray facilities will be based on customary charges calculated by methods consistent with Federal Regulations.

- c. For crossover claims the allowable payment to the provider is determined not by the Alabama Medicaid Agency but by Medicare. The Alabama Medicaid Agency will pay no more than the part of the allowable payment not paid by Medicare and other insurers who are obligated to pay part of the claim.

3. Physicians and Other Practitioners

**Effective Date: 01/01/12**

- a. Physician Fee Schedule Payment: A statewide maximum payment will be calculated for each service designated by a procedure code recognized by the Alabama Medicaid Agency as designating a covered service. To determine payments for procedure codes without an established Medicaid rate, the Alabama Medicaid Agency will base rates on the current Medicare rate, and if not available the average commercial rate. Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates effective January 1, 2012. Current rates are published and maintained on the agency's website at [http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.6\\_Fee\\_Schedules.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx). Payment rates are the same for both governmental and non-governmental providers except as noted below.

1. Rural Physician (Supplemental/Enhanced) Payment:

- (i) Providers in rural counties whose specialty is OB/GYN, Family Practice, General practice or Pediatrics, will be paid an enhanced rate for global delivery codes and delivery codes only. These rates can be found at the following link: [http://www.medicaid.alabama.gov/documents/6.0\\_Providers/6.6\\_Fee\\_Schedules/6.6\\_Physician\\_Rural\\_Rate\\_Fee\\_Sched\\_3-25-12.pdf](http://www.medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Physician_Rural_Rate_Fee_Sched_3-25-12.pdf)
- (ii) In order to increase provider participation and improve access to care, both governmental and non-governmental providers of all specialties in rural counties will be paid an additional \$1.00 per office visit or hospital visit.

2. Physician Access (Supplemental/Enhanced) Payment: In order to maintain adequate access to specialty faculty physician (all specialties including general practice, family practice, and general pediatrics) services as required by 42 USC 1396(a) (30) and 42 CFR 447.204, enhanced rates will be paid to teaching physicians. Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children's hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds. Payments will be added to the fee-for-service rate and reconciled annually. The provider's average commercial rate demonstration will be updated annually.

Enhanced rates have been established based on 2011 Medicare rates. The Agency's rates were set as of January 1, 2012, and are effective for services provided on or after that date. These rates can be found at the following link:

[http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.6\\_Fee\\_Schedules.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx)

- a. Calculation of the rates for teaching physicians is described as follows:
  - (i) Identify Medicare rates for the most recent full calendar year.  
Applicable rates are obtained in the following manner:
    - a. If more than 50 percent of the claims identified in the calculation period were performed in a non facility setting, Medicaid will use the non facility Medicare physician fee schedule.
    - b. If 50 percent or more of the claims identified in the calculation period were performed in a facility setting, Medicaid will use the facility Medicare physician fee schedule for that teaching facility.
  - (ii) Obtain the rates paid by the top five commercial insurance companies in Alabama for each public university system for the most recent full calendar year.
  - (iii) Obtain the adjudicated units of service by procedure code for the, most recent full calendar year. The State identifies adjudicated claims through Medicaid's MMIS system, that were processed during the most recent full calendar year for services performed by eligible physicians at approved places of service. Approved places of service include a hospital sponsored location such as an inpatient hospital, outpatient hospital, hospital-based clinic or a hospital-affiliated clinic. The following services are excluded from these claims: clinical diagnostic lab procedures, services provided to dual eligibles, and the technical component of radiology services. Anesthesia payment is based on a fifteen minute unit of service as well as a base payment.
  - (iv) Calculate the aggregate commercial payment equivalent for the most recent full calendar year by multiplying the Medicaid units identified in (iii) above by the commercial rates identified in (ii), then combine the payments for all services. This produces the Total Commercial Equivalent Payment Amount.
  - (v) Calculate the equivalent Medicare payments for the most recent full calendar year by multiplying the Medicaid units from (ii) above by the Medicare rates identified in (i), then combine the payments for all services. This produces the Total Medicare Equivalent Payment Amount.

(vi) Divide the Total Commercial Payment Amount by the Total Medicare Equivalent Payment Amount to determine the aggregate Average Commercial Rate Percentage of Medicare.

(vii) Based on the average commercial rate demonstration results, the rates for the teaching physicians shall be 150% of the applicable Medicare rate.

(viii) Calculated reimbursement rates for all numeric procedure codes will be rounded to the nearest dollar. Rates for procedure codes starting with an alpha character will be rounded to the nearest penny.

(ix) Procedure codes not recognized by Medicare are ineligible for the enhanced payment.

**Effective Date: 04/01/90**

- b. For Medicare crossover claims, refer to item 19 in this attachment.

**Effective Date: 01/01/12**

- c. Payment to Certified Registered Nurse Anesthetists is 80% of the maximum allowable rate paid to physicians for providing the same service.

**Effective Date: 01/01/12**

- d. Payment to physician-employed Physician Assistants and Certified Registered Nurse Practitioners is 80% of the maximum allowable rate paid to physicians for providing the same service except for injectables and laboratory procedure. Injectable and Laboratory procedures are reimbursed at 100% of the amount paid to physicians.

**Effective Date: 01/01/12**

- e. Pharmacists, employed by pharmacies participating in the Alabama Medicaid program, are reimbursed a vaccine administration fee established at the same rate paid to physicians. The Agency's rate for vaccine administration was set as of January 1, 1999, and is effective for services on or after that date. All rates are published on the Agency's website at [www.Medicaid.alabama.gov](http://www.Medicaid.alabama.gov). Except as otherwise noted in the plan, state developed rates are the same for both governmental and private providers.

## Physician Services

### **Attachment 4.19-B: Physician Services**

The state will continue to reimburse for services provided by physicians with a primary specialty designation of family medicine, pediatric medicine or internal medicine as if the requirements of 42 C.F.R. § 447.400 remain in effect. The rates will be those in effect for these services and providers during CY 2014. State of Alabama, general fund fiscal year 2015 appropriations allow for enhanced payments with dates of service January 1, 2015 through September 30, 2015. A provider must meet one of the following requirements listed below to qualify for the Alabama Medicaid Physicians Primary Care Enhanced Rates "Bump" Program.

- a. A provider must be Board certified with a specialty or subspecialty designation in family medicine, general internal medicine, or pediatrics that is recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA), and must actually practice in their specialty.
- b. A NON-board certified provider who practices in the field of family medicine, general internal medicine, or pediatrics or a subspecialty under one of these specialties, is eligible if he/she can attest that sixty percent of their paid Medicaid procedures billed are for certain specified procedure codes for evaluation and management (E&M) services and certain Vaccines for Children (VFC) vaccine administration codes during the most recently completed CY or, for newly eligible physicians, the prior month.

### **Method of Payment**

The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

### **Primary Care Services Affected by this Payment Methodology**

This payment applies to Evaluation and Management (E&M) billing codes 99201 through 99499 that are considered reimbursable by Alabama Medicaid. A list of codes and current rates are published and maintained on the agency's website at

[http://medicaid.alabama.gov/documents/6.0\\_Providers/6.6\\_Fee\\_Schedules/6.6\\_Physician\\_ACA%20Primary\\_Care\\_Fee\\_Schedule\\_Revised\\_3-1-14.pdf](http://medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Physician_ACA%20Primary_Care_Fee_Schedule_Revised_3-1-14.pdf)

### **Physician Services – Vaccine Administration**

The state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 C.F.R. § 447.400(a) at the regional maximum administration fee set by the Vaccines for children program.

The Alabama Medicaid Agency requires VFC administration fees to be billed using the specific product code (vaccine codes).

The following single product (vaccine) codes have been billed in lieu of vaccine administration codes since the inception for the VFC Program in Alabama.

90633 90636 90645 90647 90648 90649 90650 90655 90656 90657 90658 90660  
90669 90670 90680 90681 90696 90698 90700 90702 90707 90710 90713 90714  
90715 90716 90718 90721 90723 90732 90733 90734 90744 90748.

These codes will be cross walked to procedure 90460 for vaccine administration for eligible providers under 42 C.F.R. § 447.400.

**Effective Date of Payment**

**E & M Services**

This reimbursement methodology applies to services delivered between January 1, 2015 and September 30, 2015. All rates are published at ([www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)).

**Vaccine Administration**

This reimbursement methodology applies to services delivered between January 1, 2015 and September 30, 2015. All rates are published at ([www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)).

Supersedes Page: None

4. Prescribed Drugs

**Effective Date: 07/01/91**

a. Medicaid pays for covered outpatient drugs prescribed by doctors of medicine, osteopathy, and dentistry legally licensed to prescribe the drugs authorized under the program and dispensed by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws.

**Effective Date: 10/01/13**

b. Multiple Source Drugs. Reimbursement for covered multiple source drugs in the Medicaid Program shall not exceed the lowest of:

- (1) The federally mandated upper limit (FUL) for certain multiple source drugs as established and published by CMS plus a reasonable dispensing fee; or
- (2) The Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee. AEAC is defined by Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, Wholesale Acquisition Cost (WAC) + 0%; or
- (3) The provider's Usual and Customary charge to the general public for the drug; or
- (4) The Alabama State Maximum Allowable Cost (State MAC) plus a reasonable dispensing fee. The Alabama State MAC is defined as the AAC of a drug multiplied by 1.0 that will apply to all multiple source drugs within a particular grouping.

(a) **Reimbursement Methodology for the Alabama State MAC**

The State MAC reimbursement will apply to certain multiple source drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Alabama Medicaid Agency.

- Drugs are subject to a State MAC if there is at least one non-innovator multiple source alternative product available.
- The Alabama Medicaid Agency or its designated representative will collect and review pharmacy invoices and other information deemed necessary by the Alabama Medicaid Agency in an effort to determine AAC in accordance with applicable State and Federal law.
- This information will be collected from Medicaid-participating pharmacies via surveys. The AAC is multiplied by 1.0 to derive the State MAC rate that will apply to all multiple source drugs within the particular grouping.
- If the AAC no longer represents a drug's market price due to a drug shortage or other emergency situation, the Alabama Medicaid Agency will conduct a review and, if applicable, adjust the AAC to represent the drug's current market price, or apply WAC +0%.

**EXCEPTION:**

The FUL and/or State MAC may be waived for a brand innovator multiple-source drug. For these cases the prescriber must provide documentation of the medical necessity for the brand name rather than the available generic equivalent and receive an override.

- c. Other Drugs. Reimbursement for covered drugs other than multiple source drugs shall not exceed the lowest of:
- (1) The Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee. AEAC is defined by Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, Wholesale Acquisition Cost (WAC) +0%; or
  - (2) The provider's Usual and Customary charge to the general public for the drug; or
  - (3) For blood clotting factor products, the Average Sales Price (ASP) + 6% plus a reasonable dispensing fee.
- d. Dispensing Fees. A reasonable dispensing fee is set by the Agency. This fee is reviewed periodically for reasonableness and, when deemed appropriate by Medicaid, may be adjusted. The dispensing fee paid by the Agency effective 9/22/10 is \$10.64.

No payments made pursuant to methods and standards described in this Attachment 4.19-B will exceed upper limits established in 42 CFR Section 447, Subpart D.

- e. The upper limits detailed in 42 CFR §447.512 which govern Medicaid State Agency reimbursement to providers of prescribed drugs shall also apply in cases where prescribed drugs are furnished as part of SNF or ICF services or under prepaid capitation arrangements. Contracts between the State Agency and the underwriter, carrier, foundation, health maintenance organization, or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement of prescribed drugs.
- f. The Medicaid recipient shall pay the maximum allowable copayment under Federal law or administrative regulations for each prescribed drug received under the Medicaid program, except for designated exemptions. The allowable copayment amount shall be collected by the dispensing pharmacy and credited against the Medicaid payment to the pharmacy for drugs per copay table in Attachment 4.18-A. Designated exemptions include prescriptions for pregnant women, Family Planning drugs, those used for Medicaid recipients under 21 years of age, and drugs for Medicaid recipients institutionalized in long term facilities.

5. Prosthetic Devices

Reasonable, customary charges submitted by the vendor, not to exceed the amount payable under Title XVIII, Part B or the amount paid by the general public.

**Effective Date: 10/1/14**

The pricing methodology is 80% of the 2005 Medicare allowable amount as listed on the Alabama Supplies, Appliances, and DME Fee Schedule. The agency's fee schedule rate is in effect for services provided on or after October 1, 2014. All rates are published on the Medicaid Agency's website ([www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)). Except as otherwise noted in the plan, the Medicaid developed fee schedule rates are the same for both governmental and private providers.

6. Eyeglasses

- a. Eyeglasses are procured from a central source selected through the State competitive bid system. Payment is based on reasonable charges, obtained through the bidding procedures, which are included in a contract between Medicaid and the central source contractor. The contracted charges will not exceed the amount paid by the general public or other third party organizations.
- b. The contract between Medicaid and the central source contractor will be on file and available for review in the office of the Single State Agency.
- c. Eyeglasses may, at the option of the provider, be procured from the central source contractor or from any other source, but at a price not to exceed the contract price charged by the central

source. However, the quality of the eyeglasses must be equal to or better than that provided by the central source contractor.

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7. Early and Periodic Screening Diagnosis and Treatment of Individuals under 21 Years of Age
- a. Screening providers (including physicians - not included elsewhere in this State Plan) - Governmental providers will be paid on an interim rate which will be the present rate paid to the Department of Public Health for screening. This rate will be adjusted to actual cost for each governmental agency. Non-governmental providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.
  - b. Hearing aid vendors - Providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.
  - c. Physical Therapy - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19-B, Number 3a of the State Plan.
  - d. Occupational Therapy - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
  - e. Speech-Language-Hearing Therapy - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
  - f. Psychology - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
  - g. Chiropractic - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
  - h. Podiatry - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
  - i. Christian Science - the reimbursement methodology is 75% of the usual and customary charge for licensed Christian Science providers in the State of Alabama.

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Supersedes  
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- j. Private Duty Nursing - the reimbursement methodology is based on an hourly rate for a registered nurse or licensed practical nurse. Rates are established using the lowest rates for agencies surveyed.
- k. Transplant (heart-lung, pancreas-kidney and lung) - the reimbursement methodology is the same as identified in Attachment 4.19-B, Number 18 of the State Plan.
- l. Air Ambulance - the reimbursement methodology is the same as identified in Attachment 4.19B, Number 11 of the State Plan.

- m. School Based Services: Medicaid services provided in schools are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an Individualized Education Program, (IEP) or an Individual Family Service Plan (IFSP). Covered services include the following:
1. Audiology Services
  2. Occupational Therapy
  3. Physical Therapy
  4. Counseling Services
  5. Personal Care Services
  6. Speech/Language Services
  7. Nursing Services
  8. Transportation Services

For the purpose of making interim Medicaid payments to LEA providers, the Alabama Medicaid Fee Schedule will be applied to claims submitted to the Medicaid Management Information System (MMIS) for the above services. Except as noted otherwise in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Audiology Services, Occupational Therapy, Physical Therapy, Counseling Services, Personal Care Services, Speech/Language Services, and Nursing Services. The agency's fee schedule rate is in effect for services provided on or after 4/1/12. All rates are published at:

[http://medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.6\\_Fee\\_Schedules.aspx](http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx).

For transportation services, an interim rate will be determined based on a rate that represents the actual cost of providing the transportation service, upon final approval of the SPA and cost allocation plan

- (A). Direct Medical Services Payment Methodology:  
Beginning with cost reporting period April 1, 2012, the Alabama Medicaid Agency will begin settling Medicaid reimbursement for direct medical services at cost for all Local Education Agencies (LEA's). This reimbursement at cost methodology will include a quarterly Random Moment Time Study, an annual cost report and reconciled settlement as well as quarterly interim settlements. The quarterly interim settlements for services will be based on the quarterly Random Moment Time Study and use of the interim cost reports compiled on a quarterly basis. However, for transportation services, Item (b) provides the transportation payment services methodology.

Effective for services provided on or after April 1, 2012 school based services will be reimbursed at cost according to this methodology described in the state plan.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients in the LEA, the following steps are performed:

1. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services personnel listed in the descriptions for the covered Medicaid services delivered by school districts. Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, direct materials, supplies, and equipment. Medical devices and equipment are only allowable for the provision of direct medical services. For items not previously approved, the LEA must use a pre-approval process to determine suitability, coverage, and reimbursement of medical supplies, material, and equipment. The following process must be followed by the schools at a minimum:
  - a) The medical device must be approved and effective (i.e., not experimental) and within the scope of the school based services shown as covered in the Medicaid state plan;
  - b) The use of the device must be determined suitable for the individual; and
  - c) The service or device must be approved by one of the covered medical professionals and reviewed by the Alabama Medicaid Agency.

These direct costs are accumulated on the annual cost report, resulting in total direct costs. The cost report contains the scope of the cost and methods for cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

2. The net direct cost for each service is calculated by applying the direct medical services percentage from the CMS-approved time study to the direct cost in 1 above. A time study, which

incorporates a CMS-approved Random Moment Time Study methodology, is used to determine the percentage of time medical service personnel spend on IEP-related medical services, and general and administrative time. This time study will assure that there is no duplicate claiming relative to claiming for administrative costs.

3. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Alabama public school districts use predetermined fixed rates to indirect costs. The State Department of Education (SDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.
4. Net direct costs and indirect costs are combined.
5. Medicaid's portion of total net costs is calculated by multiplying the results for Item 4 by the ratio of the total number of Medicaid covered children with IEPs and IFSPs by the total number of children with IEPs and IFSPs.

(B) Transportation Services Payment Methodology

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

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

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

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

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

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

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

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

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

3) Net Direct Costs and Indirect costs are combined.

(C). Certification of Costs Process:

On a quarterly basis, each provider will certify through its cost report, its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(D). Cost Report Process:

For Medicaid services listed in Paragraph (a) 1-10 provided in schools during the state fiscal year, each LEA provider must complete the following:

1. Quarterly Interim Settlement Cost Report. This Interim Settlement Cost Report is due within 90 days from the close of a quarterly reporting period,
2. Annual Settlement Cost Report. An annual cost report to reconcile the LEA's final settlement is due on or before April 1 following the reporting period.

The primary purposes of the cost report process are to:

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

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

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

(E). The Cost Reconciliation Process:

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

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

(F). The Cost Settlement Process

EXAMPLE:

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

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

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