Rule No. 560-X-57-.10 Payment Methodology for Covered Services

(1) Payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

~~(2) For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month, but no single claim can cover services performed in different months. If the submitted claim covers dates of service, part or all of which were covered in a previously paid claim, it will be rejected. Payment will be based on the number of units of service reported for each procedure code listed in the Medicaid Provider Manual.~~

(23) The rate will be based on audited past performance with consideration being given to the medical care portion of the consumer price index and renegotiated contracts. Interim fees may be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

(34) All claims for services must be processed within six months after end of waiver year. At the end of the waiver year, the operating agency will be audited, and a final rate will be calculated based on actual allowable cost for the year divided by the number of services provided during the year. Any difference between the actual allowable cost and the revenues received based on the interim rate will be adjusted.

(45) Accounting for actual cost and units of services provided during a waiver year must be accomplished on CMS-372 reports. The following accounting definitions will be used in establishing new interim fees:

(a) A waiver year consists of the 12 months following the start of any waiver year.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public (governmental) provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the State agency.

(c) The services provided are reported and paid by dates of service. Thus, all services provided during the 12 months of the waiver year will be attributed to that year.

(65) Provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the cost. The administrative portion will be divided into 12 equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver year is audited, this cost, like the benefit cost, will be determined and a lump sum settlement will be made to adjust that year's payments to actual cost.

Author: Antoinette Hardy, Administrator, LTC Healthcare Reform Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based SAIL Waiver.
History: Rule effective June 1992. Amended February 10, 1994, and October 12, 1996. **Amended:** Filed February 19, 1999; effective April 12, 1999. **Amended:** Filed March 20, 2001; effective June 15, 2001. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Amended: Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008. **Amended:** Filed August 20, 2020.