

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS/PROCEDURES FOR DETERMINING NURSING FACILITY REIMBURSEMENT

I. Introduction

Effective Date: 09/01/91

A. The following sections summarize the methods and procedures used by the Alabama Medicaid Agency (hereinafter "Agency") in determining proper reimbursement to nursing facilities. Under this plan, all facilities are considered the same with the exception of NF/IMD (Nursing Facility/Institution for Mental Disease) and NF/IDD (Nursing Facility/Institution for the Developmentally Disabled). This summary does not apply to the classification of ICF/MR, which is an additional functional classification established by the Agency.

Effective Date 10/01/90

B. All reimbursement will be determined in compliance with generally accepted accounting principles, principles outlined in the State Plan, Medicare (Title XVIII) Retrospective Reasonable Cost Principles of Reimbursement, and principles and procedures promulgated by the Agency to provide reimbursement of provider costs which must be incurred by efficiently and economically operated nursing facilities. The Agency may, in the absence of applicable procedures, standards, and provisions within published Regulations, apply certain reasonability standards to expenses for which reimbursement is sought, to determine whether reimbursement should be made. The granting of variances to the Agency Reimbursement Principles will be discretionary with the Agency, based on the submission of substantiating documentation and convincing evidence by the provider that services can be provided in a more cost efficient manner if the variance is granted.

C. Providers/Administrators are expected to conduct their business in an efficient and cost-effective manner and to seek reimbursement only for those costs which must be incurred in the conduct of an economically and efficiently operated nursing facility.

D. The Agency will conduct desk reviews and on-site audits to insure that only allowable costs are allowed and reimbursed, and the Agency's previous failure to disallow costs shown in cost reports will not insure their continued allowance if those costs are identified as unallowable. In addition, attempts by a provider to include costs previously disallowed by the Agency may result in additional investigation by the Agency or investigation by the Alabama Attorney General.

E. The Agency recognizes the impact of inflation on all costs associated with doing business and has taken this into account in initiating the application of the Agency Inflation Index. The Alabama Medicaid Inflation Index shall be based upon the economic indicators as published by Data Resources, Inc. (DRI) for the Department of Health and Human Services. The indicators shall be the Market Basket Index of Operating Costs - Nursing Facility, which are published quarterly, whereas the Medicaid fiscal year for cost reporting and rate setting purposes ends on June 30. Therefore, the Medicaid Inflation Index for a rate period will be the DRI Index for the twelve-month period ending on the calendar quarter for which the index has been published or made available at October 1st of each year.

II. Cost Recording and Cost Reporting Procedures

A. All nursing facilities participating in the Alabama Medicaid Nursing Facility Program are required to report costs for the reporting period July 1 to June 30 of each year. The costs included are required to be detailed on the cost reports and must have been recorded by the facility on the basis of generally accepted accounting principles and in accordance with the accrual method of accounting.

B. Each nursing facility must submit its costs for the reporting period on the uniform cost report form provided by the Agency. Each complete cost report must be verified and must be received by the Alabama Medicaid Agency on or before September 15 for the report period ending the previous June 30. Should September 15 fall on a holiday or weekend, the complete, verified cost report must be received by the Alabama Medicaid Agency on the next working day. Failure to comply with the established deadline may result in the imposition of penalties against the facility. Nursing facilities ceasing their operation or terminating their participation in the program must submit a final cost report within seventy-five (75) days of cessation or termination.

C. All nursing facilities are required to maintain financial and statistical records for each cost reporting year, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least three (3) years following the date of submission of the cost report form to the Alabama Medicaid Agency. Records required by the Alabama Medicaid Agency to be maintained are specified in the Nursing Home Reimbursement Chapter of the Alabama Medicaid Agency Administrative Code. These records must be made available upon request to representatives of the Alabama Medicaid Agency or the United States Department of Health and Human Services.

D. The Alabama Medicaid Agency shall retain all uniform cost reports submitted in accordance with the requirements of the Alabama Medicaid Agency for a period of three (3) years following the date of submission of each report and will maintain those reports pursuant to recordkeeping and reporting requirements of the Department of Health and Human Services.

E. For hospital related facilities and domiciliary facilities, the step-down cost findings method must be applied to its allowable costs to ascertain the costs of the various services provided during the reporting period.

III. Allowable Costs

Effective Date: 09/01/91

A. Allowable Costs shall include all items of expense which providers must incur in the provision of routine services. Routine services means the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities.

1. Management and Administrative Costs - Specific, although not all inclusive, allowable management and administrative costs are set out in the Nursing Home Reimbursement Chapter (Chapter 22) of the Alabama Medicaid Agency Administrative Code. All nursing facilities will be arrayed by the number of beds in the facility, and those operating costs deemed allowable by the Alabama Medicaid Agency for each provider will be separated into two groups, 75 beds or less and 76 beds and over.
2. Interest Expenses - For this expense to be allowable, it must be reasonable, necessary, and incurred strictly to satisfy a financial need directly related to patient care. Additionally, interest paid to a related party will not be characterized as allowable.
3. Laundry Expenses - Allowable costs will be limited to the laundry costs which are ordinary and necessary to the operation of the nursing facility and will not include costs associated with the personal laundry of residents. The facilities will be reimbursed for personal laundry at a daily rate determined by the Agency. This rate is determined by Medicaid by an analysis of laundry expenses and income to determine a net revenue. The revenue is divided by total patient days.
4. Travel Expenses - Travel expenses will be allowed as long as those costs are calculated in strict compliance with Alabama Medicaid Agency standards as set out in the Agency's Administrative Code.

5. Property Costs - Those costs which are in accord with the standards established by the Alabama Medicaid Agency relating to property will be allowed. A Fair Rental System, as outlined in Chapter 22 of the Alabama Medicaid Agency Administrative Code, will be used to reimburse property costs.
6. Funding Qualified Retirement Plans - Cost of funding will be allowed for either a defined benefit plan or a defined contribution plan. Any other plan may be considered by the Alabama Medicaid Agency on an individual basis in light of the standards and principles set by the Alabama Medicaid Agency.
7. For nursing facilities which are part of hospitals, excessive allocations from the hospitals to the nursing home will be disregarded.

B. All allowable expenses will be examined to determine if costs are incurred from a related party in which case only the net costs to the related party will be allowed, and those net costs cannot exceed the fair market value of the goods or services.

C. All similar allowable costs will be categorized into one of four (4) groups, as follows:

1. Operating Costs - Administrative costs including medical records consultant.
2. Direct Patient Care Costs - Nursing services costs, raw foods, medical director, nursing consultant, pharmacy consultant, and dental consultant.
3. Indirect Patient Care Costs - Costs other than operating cost, direct patient care costs, and property costs such as: Plant operations, dietary (minus raw foods), laundry (less costs associated with patient personal laundry), activities, social services, housekeeping, beauty and barber (if provided free of charge by the facility), dietary consultant, and social services consultant.
4. Property Costs - Gross asset value, as defined in Chapter 22, of land, buildings, and equipment reduced by outstanding mortgage debt. Interest expense, property taxes, and property insurance are also included.

Effective Date: 10/01/90

D. Total costs as reported will be offset by certain income items or receipts of the facility, as more fully described within published Regulations.

Effective Date 10/01/93

E. Effective October 1, 1990, rates to nursing facilities took into account the costs of nursing facility's compliance with the requirements of §1919(b) (other than paragraph (3)(F) thereof), (C) and (d) of the Social Security Act.

1. For the period beginning October 1, 1990, nursing facilities were permitted to budget estimated costs of compliance with OBRA 87. Each facility submitted a budget for the estimated annual cost for each position to be filled because of OBRA 87 requirements. Funding would be made available to cover the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Additional health care staff was authorized as outlined below:

1 RN per 50 Residents for assessments
1 LPN per Facility for rehab nursing
1 Qualified Social Worker for facilities of 120 beds and larger
1 Activities person per 60 Residents

Change staffing ratios for nurse aides:

SHIFT	FROM	TO
7 - 3	1 - 10	1 - 6
3 - 11	1 - 15	1 - 10
11 - 7	1 - 25	1 - 20

Quarterly, beginning October 1, 1990, through April 1, 1991, each facility submitted a hiring form reporting the annual salary of actual staff, as authorized in approved budgets, hired that quarter. Such costs per day were added to the existing per diem rates outside the ceiling limitation. We estimated the average cost of those budgeted costs to be approximately \$5.44 per day.

2. Effective September 1, 1991, a new reimbursement methodology was implemented to provide for maintaining the highest practicable physical, mental, and psychosocial well-being of each resident. Estimated OBRA 87 costs based on the above staffing requirement were added to the per diem rates and were considered in setting ceiling limitations.

3. Effective January 1, 1992, nursing home reform costs were included in establishing the per diem rates and were included in setting ceiling limitations. This was done by taking the reported nursing home reform expenses in the June 30, 1991, cost report and adding, as a budget figure, the difference between nursing home reform expenses in the cost report and the dollar amount authorized on the October 1, 1990, budget form. Effective with the June 30, 1992 cost reports, and continuing forward, the cost of nursing home reform will be included in with all nursing facility allowable costs.

Effective Date 10/01/90

IV. Audits and Rate Computation

A. Nursing facilities will be audited by members of the Audit Staff of the Alabama Medicaid Agency or outside auditors, to insure that reimbursement is made only for allowable costs, as detailed in Section B.

1. A desk review and analysis is made on data submitted on each uniform cost report. The analysis consists of a complete review of historical costs and an examination of costs for the reporting period as set out in the report. Subsequent to the desk review and analysis of all submitted cost reports, a payment rate is established for each facility. This rate is subject to adjustment resulting from an in-depth audit of that facility's records.

2. The Alabama Medicaid Agency will conduct analyses of the uniform cost reports by January 1 of each year for those reports covering the reporting period ending the previous June 30 to verify that a complete cost report has been filed by each facility and to verify that it has properly detailed the costs for which it is seeking reimbursement.

Effective Date 10/01/98

3. Each nursing facility will be audited as necessary by an in-depth, on-site audit. Unless a waiver is specifically granted by the Alabama Medicaid Agency, all records which substantiate the information reflected in the cost report(s) being audited are to be made available at the facility, and Alabama Medicaid Agency's audit staff is to be provided adequate facilities and privacy to conduct the audit.

4. Subsequent to an audit of a facility, a final report of audit will be forwarded to the facility and certain disallowances of costs as reported on the cost report may be necessitated by the findings of the audit staff, resulting in a change of the per diem reimbursement rate. It is also possible that an audit may obviate underpayments by the Alabama Medicaid Agency to the provider, both situations resulting in the need to either recoup from or pay to the provider any over or underpayments due.

5. This settlement will be achieved in either event by a lump sum payment from the party underpaying (Alabama Medicaid Agency or being overpaid (the provider), and an adjustment in the per diem rate.

6. Prior to collection of any amount due the Alabama Medicaid Agency as a result of disallowances contained in the final report of audit, the facility will be given thirty (30) days to contest Alabama Medicaid Agency's findings and to request an informal conference to present its position. Subsequent to any informal conference, an administrator who feels the results of the informal conference are adverse to his facility may request a fair hearing in writing within fifteen (15) days of Alabama Medicaid Agency's mailing its determination on the issues presented at the informal conference. All fair hearings are conducted in accordance with Alabama Medicaid Agency regulations governing fair hearings. The Alabama Medicaid Agency will account for overpayments found in audits on the quarterly statement of expenditures no later than sixty (60) days after the overpayment was found.

7. Nursing Facilities will be reimbursed on a reasonable cost-related basis, and payments will be based on the lower of the facility's billing rate or maximum reimbursement rate or the facility's usual and customary charge to the general public for the same range of services minus applicable patient income.

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8. For reimbursement, all nursing facility providers will be grouped into three (3) functional categories: NF, NF/IMD, and NF/IDD. All similar allowable costs will be categorized into one of four (4) groups: operating costs, direct patient care cost, indirect patient care cost, and property cost. NF/IMD and NF/IDD facilities will be exempt from all ceilings.

(a) Operating Costs - The ceiling for operating costs will be at the median cost per patient day plus 5% for each of the two bed size groupings. Actual allowable reported cost per patient day up to the ceiling will be used to establish the rates.

The allowable management and administrative cost for each facility will be divided by reported patient days. All nursing facilities will be grouped by the number of beds in the facility and the operating costs for each facility will be separated into two bed size groupings, 75 beds or less and 76 beds and over. Each grouping will be arrayed by the cost per patient day. The median plus 5 percent will be determined for each grouping that will be the ceiling. This ceiling, or actual cost, whichever is less will be used for each provider's rate computation.

Ceilings are determined annually based upon allowable cost submitted in the Alabama Medicaid Nursing Home cost reports ending June 30th of each year.

(b) Direct Patient Care Cost - The ceiling for the direct patient care costs is the median cost per patient day plus 10%. Actual allowable reported cost per patient day plus 11% not to exceed the established ceiling plus 11% will be used to establish the rates.

Direct care costs, consisting of nursing services, raw foods, medical director, nursing consultant, pharmacy consultant and dental consultant for each facility will be divided by reported patient days. These costs per patient day will be arrayed and the ceiling for the direct patient care cost center will be the median cost per patient day plus 10 percent. The provider's actual allowable reported cost per patient day plus 11 percent not to exceed the established ceiling plus 11 percent whichever is less will be used for each provider's rate computation.

Ceilings are determined annually based upon allowable cost submitted in the Alabama Medicaid Nursing Home cost reports ending June 30th of each year.

(c) Indirect Patient Care Cost - The ceiling for indirect patient care cost is the median cost per patient day plus 10%. Actual allowable reported cost per patient day plus 50% of the difference between reported cost and the ceiling up to the ceiling amount will be used to established rates.

Costs for plant operations, dietary (minus raw foods), laundry (less costs associated with patient personal laundry), activities, social services, housekeeping, beauty and barber (if provided free of charge), dietary consultant, social services consultant, and other allowable costs,

will be divided by reported patients days. These costs per patient day will be arrayed and a median cost per patient day will be determined. The ceiling for indirect patient care costs is the median cost per patient day plus 10 percent. The providers actual allowable reported cost per patient day plus 50 percent of the difference between actual allowable cost and the established ceiling up to the ceiling amount, will be used for each provider's rate computation.

Ceilings are determined annually based upon allowable cost submitted in the Alabama Medicaid Nursing Home cost reports ending June 30th of each year.

(d) Property Cost - Property costs will be reimbursed under a fair rental system as set out in the Nursing Facility Reimbursement Chapter (Chapter 22) of the Alabama Medicaid Agency Administrative Code. Facilities categorized as NF/IMD will be reimbursed a usage allowance of 2% for building values and 6 2/3% for equipment instead of the fair rental.

Current Asset Values (CAV) for Nursing Homes are based upon historical data rebased annually using Marshall Swift Evaluation. Effective October 1, 2020, the CAV will be increased by 41.03% due to increased costs of Nursing Homes. Allowable interest expense, property taxes and property insurance are determined from the annual Alabama Medicaid Nursing Home cost report ending June 30th of each year or the latest available cost report.

(e) Reimbursement will be the sum of these cost groupings as adjusted under the provisions of Chapter 22 of the Alabama Medicaid Agency Administrative Code.

Allowable cost is determined based upon the annual Alabama Medicaid Nursing Home cost report ending June 30th of each year of the latest available cost report.

Effective Date: 10/01/90

9. The on-site audits conducted in accordance with generally accepted auditing standards will result in an audit report which will contain the auditor's opinion as to whether, in all material respects, the uniform cost report includes only expense items allowable under the Alabama State Plan, as detailed under Section III of this attachment, and that the expense items included are accurately determined, attributed, and are reasonable. These audit reports shall be kept by the Alabama Medicaid Agency for at least three (3) years following the date of submission of such reports, and will be maintained pursuant to the record keeping and reporting requirements of 42 CFR §431.16.

B. Alabama has determined that the payment rates resulting from the Alabama Medicaid Agency methods and standards are at least equal to the level at which the State calculates a facility can be economically and efficiently operated.

C. Payment rates to SNF's and ICF's are determined prospectively with an annual recalculation of applicable rates. Alabama does not, however, adjust the per diem reimbursement rates to a nursing home provider based on service deficiencies or quality of service.

V. Payment Assurances and Payment Limitations

A. The State will pay each provider of nursing care services, who furnishes services in accordance with the provisions of the State Plan, the amount determined for services furnished under said Plan.

B. State payments made pursuant to the State Plan for nursing facilities shall not exceed the general payment limits established by the United States Congress and implemented through Agency regulations, when such limits are established by the Secretary of Health and Human Services. These payments shall under no circumstances exceed the facility's customary charges to the general public for services.

C. It is a primary intent that payments made in accordance with the methods, provisions, and standards of the Alabama Medicaid Agency Nursing Facility Reimbursement chapter of the Agency's Administrative Code will serve to ensure the participation of a sufficient number of providers of services in the program so that medical care and services included in the State Plan are available to eligible persons at least to the extent that they are available to the general public.

D. The Alabama Medicaid Agency will pay nursing facilities a supplemental fee-for-service payment for care provided to ventilator-dependent residents who are eligible for Medicaid benefits.

The nursing facility and the ventilator-dependent/tracheostomy resident must meet specific requirements established by the Medicaid Agency.

The nursing facility must meet and comply with the following in order to be considered to receive the supplemental fee for ventilator-dependent/tracheostomy residents:

- Comply with all of the State and federal requirements governing nursing facilities, including physical and life safety requirements
 - Ensure that an RN or LPN has primary responsibility for the unit
 - Ensure that in-house respiratory services are provided by a licensed Respiratory Therapist 24 hours per day
 - Provide a program of initial training and ongoing in-service training for direct care staff
 - Ensure that physician visits are conducted in accordance with federal regulations for nursing facilities
 - Not accept a ventilator-dependent and/or qualified tracheostomy resident if any of the following situations exist:
 - Termination of the NF's Medicaid certification is imminent; or
 - The NF is a Special Focus Facility, under review by CMS, or the State Survey Agency, or the Alabama Medicaid Agency.
- must meet specific requirements established by the Medicaid Agency.

The nursing facility will be reimbursed the daily per diem rate determined for the nursing facility plus an additional daily payment for the ventilator-dependent/tracheostomy resident.

The supplemental fee-for-service payment will be \$120.00 and indexed annually in accordance with the cost of living increases based upon the economic indicators as published by Data Resources, Inc. (DRI) for the Department of Health and Human Services.

E. Providers who participate in the program shall accept as payment in full, those amounts paid to them in accordance with the State Plan.

VI. Compliance with Provisions, Methods and Standards

In order to assure compliance with its regulations, the Alabama Medicaid Agency has established certain penalties which may be assessed at its discretion, the details of which are fully set out in the Agency Administrative Code.

VII. Miscellaneous

A. The Alabama Medicaid Agency will utilize appropriate methods of notifying the public concerning proposed, substantial changes in methods and/or standards, and prior to the implementation of any substantial change in methods and/or standards, the public will have an opportunity to review and comment on the proposed changes.

B. Detailed information regarding the reimbursement methodology and related matters appears in Chapter 22 of the Alabama Medicaid Agency Administrative Code.

C. The regulations of the Alabama Medicaid Agency are implemented under the provisions of the Administrative Procedures Act. Through this process, the agency must publish its intent to make any changes in the reimbursement methodology. Copies of the methodology and data used to establish per diem rates may be obtained by the public upon written request and payment of a reproducing fee.

Effective Date: 5/01/02

D. In order to provide services to Alabama Medicaid recipients when there is no Alabama nursing facility with a suitable bed available that meets the medical needs of the recipient, the Agency may contract with out-of-state facilities at the other states' Medicaid reimbursement rate. The Agency will only make a placement of an Alabama Medicaid recipient into an out-of-state facility if (1) no Alabama nursing facility bed is available that meets the medical needs of the recipient, (2) in-state alternatives for providing services have been exhausted, and (3) prior approval for placement into an out-of-state facility is sought through the Agency. If the Agency determines based upon the prior approval process to make a placement of the Alabama Medicaid recipient into an out-of-state nursing facility as described in 42 CFR 435.403(e) the recipient will remain an Alabama resident. Once an Alabama nursing facility bed meeting the medical needs of the recipient is available, the recipient must return to Alabama to remain eligible for Alabama Medicaid.

Alabama will contract with out-of-state nursing facilities on an as needed basis. Alabama will use the out-of-state facility's survey conducted by its survey and certification agency. No year-end Alabama Medicaid nursing facility cost report will be required from the contracting out-of-state facility nor will there be any requirement for Alabama conducted periodic audits.

Effective Date: 10/01/20

- E. A Quality Incentive Add-on payment will be distributed to nursing homes annually.

Quality Incentive Component

For each measure, a provider is awarded points. The points are adjusted based on provider total Medicaid patient days and the resulting adjusted point value is used to determine a provider's portion of Quality Incentive funds.

Process Measures

For each process measure, each provider will be ranked and points will be awarded based on the percentage in which the provider scores in relation to the national average for the measure. For each rate period, the process measures will be calculated using the most recent four quarter average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of July 1 of the year in which the rate period begins.

1. Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine
2. Percentage of long-stay residents assessed and appropriately given the seasonal pneumococcal vaccine
3. Percentage of long-stay residents who received an antipsychotic medication

Outcome Measures

For each outcome measure, each provider will be ranked and points will be awarded based on the percentage in which the provider scores in relation to the national average for the measure. For each rate period, the outcome measures will be calculated using the most recent four quarter average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of July 1 of the year in which the rate period begins.

1. Percentage of long-stay residents who were physically restrained
2. Percentage of SNF residents with pressure ulcers that are new or worsened

The customer satisfaction process measure will be calculated as reported on the most recent Satisfaction Survey Summary Report as prepared by NRC Health. The survey measure will evaluate the combined Resident and Family response to the "Willingness to Recommend" survey element. For Year One of the Quality Incentive the Agency will only evaluate the response rate of the combined Resident and Family surveys. Starting with Year Two the points will be based on actual survey results.

Quality Incentive Add-Ons

1. To be eligible for the Quality Incentive a facility must:
 - a. Accept Medicaid recipients;
 - b. Participated and completed the most recent Satisfaction Survey by NRC Health; and
 - c. Earned a minimum of four (4) points based on the below criteria.

2. Points are awarded to a provider for each quality measure using the following criteria:

Process Measures	0.75 points	1 point	2 points	3 points	Max Points Per Provider
Flu Vaccine	*10% year over year improvement	N/A	N/A	At or Above the National Average	3
Pneumonia Vaccine	*10% year over year improvement	N/A	N/A	At or Above the National Average	3
Antipsychotic	*10% year over year improvement	At or Above the National Average	20% Above the National Average	40% Above the National Average	3

Outcome Measures	0.75 points	1 point	2 points	3 points	Max Points Per Provider
Restraints	*10% year over year improvement	N/A	N/A	At or Above the National Average	3
Pressure Ulcers	*10% year over year improvement	At or Above the National Average	5% Above the National Average	10% Above the National Average	3
Customer Satisfaction – Recommendation**	N/A	Improve TopBox Excellent score by 5-points from previous year.	Exceed National Average for Top3Box Excellent, Very Good, Good Score	Exceed National Average for TopBox Excellent Score	3

*Year over Year improvement is calculated as the change from the year preceding the current year to the current year measurement. For Year One there will be no calculation for annual improvement as it will be considered the Baseline Year performance.

**For Year One of the Quality Incentive the facility must achieve a combined response rate of thirty percent (30%) on the Resident and Family surveys. If the response rate is achieved the Facility will receive three points. If the response rate is not met, the facility will receive zero (0) points and would only be eligible for the Incentive if they achieve at least 4 points in the other categories.

- Three Quarter points for year over year improvement are only awarded to providers who do not meet the criteria to earn 1-3 points within the measure.
- Providers must have a quality score of at least the four (4) points to qualify for a quality incentive payment.
- Participation in the Quality Incentive Add-On is voluntary and a facility has the option to opt out and not participate.
- The weighted provider score for each qualifying provider is calculated by multiplying the provider quality points by the number of annualized Medicaid days as reported on the most recent June 30 cost report received by the Alabama Medicaid Agency. The payment per quality point is established by dividing the total quality budget by the sum of all weighted provider scores. The per diem quality incentive component is calculated by multiplying a provider's weighted quality score by the payment per quality point.

STATE ALABAMA

METHODS/PROCEDURES FOR DETERMINING REIMBURSEMENT RATES FOR
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)

Effective Date: 10/12/88

I. Introduction

A. The following sections summarize the methods and procedures used by the Alabama Medicaid Agency (hereinafter "Agency") in determining proper reimbursement to providers operating long term care facilities functionally classified as Intermediate Care Facilities for the Mentally Retarded.

B. All reimbursement will be determined in compliance with generally accepted accounting principles, principles outlined in the State Plan, Medicare (Title XVIII) Retrospective Reasonable Cost Principles of Reimbursement, and principles and procedures promulgated by the Agency to provide reimbursement of provider costs which must be incurred by efficiently and economically operated ICF/MRs. The Agency may, in the absence of applicable procedures, standards, and provisions within published Regulations, apply certain reasonability standards to expenses for which reimbursement is sought, to determine whether reimbursement should be made. The granting of variances to the Agency Reimbursement Principles will be discretionary with the Agency, based on the submission of substantiating documentation and convincing evidence by the provider that services can be provided in a more cost efficient manner if the variance is granted.

C. Providers/Administrators are expected to conduct their business in an efficient and cost effective manner and to seek reimbursement only for those costs which must be incurred in the conduct of an economically and efficiently operated facility.

D. The Agency will conduct desk reviews and on-site audits to insure that only allowable costs are allowed and reimbursed, and the Agency's previous failure to disallow costs shown in cost reports will not insure their continued allowance if these costs are identified as unallowable. In addition, attempts by a provider to include costs previously disallowed by the Agency may result in additional investigation by the Agency or investigation by the Alabama Attorney General's Medicaid Fraud Control Unit.

E. The Agency recognizes the impact of inflation on all costs associated with doing business and has taken this into account in initiating the application of an inflation index. The inflation index shall be based upon the economic indicators as published by Data Resources, Inc. (DRI) for the Department of Health and Human Services. The indicators shall be the Market Basket Index of

TN No. AL-92-5

Supersedes

TN No. AL-88-16

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Operating Costs - Skilled Nursing Facility, which are published quarterly, whereas the Medicaid fiscal year for ICF/MR for cost reporting purposes ends on September 30. Therefore, the inflation index for the rate period will be the DRI Index for the twelve-month period ending on the calendar quarter for which the index has been published or made available at October 1st of each year.

This factor shall be used to inflate allowable historical operating costs (excluding salaries and wages for State owned facilities). This factor shall not apply to depreciation, interest, lease payments, insurance, taxes or any other property costs. Salary increases shall be computed separately for state owned facilities. Property costs will be computed separately, and projections on these items will be allowed if they are not prohibited or limited by other provisions of this plan.

II. Cost Finding and Cost Reporting Procedures

A. All ICF/MR facilities are required to report costs for the twelve months ending September 30th of each year.

B. All ICF/MR facilities are required to detail their costs for the entire reporting year, or for the period of participation in the plan, if less than the full reporting year, for allowable costs under the Alabama Plan. These costs are recorded by the facility on the basis of generally accepted accounting principles and the accrual method of accounting. Cash basis accountability will be allowed only for those ICF/MR facilities operated by, or for, an agency of the Federal, State or county governments.

C. All ICF/MR facilities are required to report costs on the uniform cost report form provided by the State Agency. All uniform cost reports must be filed with the State Agency within sixty (60) days of the close of the cost reporting year, unless an extension is authorized, or adequate justification is provided. Failure to comply with the established deadline may result in the imposition of penalties against the facility.

D. All nursing facilities are required to maintain financial and statistical records for each cost reporting year, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least three years, plus the current year, following the date of submission of the cost report form to the State Agency. These records must be made available upon demand to representatives of the State Agency or the United States Department of Health and Human Services.

E. The State Agency shall retain all uniform cost reports submitted in accordance with paragraph "C" above for a period of three years, plus the current year, following the date of submission of such reports and will maintain those reports pursuant to the

record keeping and reporting requirements of the Department of Health and Human Services.

III. Allowable Costs

A. The following items of expense are allowable costs under the Plan:

1. All items of expense which providers must incur in meeting certification standards, to include costs involved in meeting the definition of intermediate care facility for the mentally retarded as contained in the Social Security Act or H&HS publications, costs to comply with the standards prescribed by the Secretary of Health and Human Services, costs to comply with the standards established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR §442.400 and costs to comply with any other requirements for licensing under State law. Some cost center limitations are detailed in Chapter 42 of the Alabama Medicaid Administrative Code.

2. Allowable costs include reasonable costs of providing quality care. Implicit in the intention that reasonable costs be paid is the expectation that the provider seeks to minimize its costs and that its costs do not exceed what a prudent and cost conscious buyer pays for a given item of service or product. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not allowable costs. Costs related to resident care include all necessary and proper costs involved in developing and maintaining the operation of resident care facilities and activities. Necessary and proper costs related to resident care are usually costs which are common and accepted occurrences of similar providers. They include such costs as property costs, resident care costs, maintenance costs, administrative costs, etc.

3. An allowance for return on equity capital for proprietary providers is also provided. This rate of return shall be equal to the average of the rate of the Federal Hospital Insurance Trust Fund for the twelve-month period ending September 30th of each cost reporting year.

Effective Date: 03/01/96

4. Depreciation will be an allowable cost for non-governmental providers. In lieu of depreciation for the use of buildings and improvements, State and local units of government will be compensated through use allowance. A use allowance for buildings and improvements may be computed at an annual rate not exceeding two percent of acquisition cost.

Major movable equipment for State owned and operated local units will be depreciated.

Effective Date: 10/01/92

5. Interest Expenses - For this expense to be allowable, it must be reasonable, necessary, and incurred strictly to satisfy a financial need directly related to patient care. Additionally, interest paid to a related party will not be characterized as allowable.

6. Bad debts of patients and charity and courtesy allowances shall not be included in allowable costs.

7. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable items purchased elsewhere. Providers shall identify such related organizations and costs in their cost reports.

8. A multiple-facility complex which has an ICF/MR and other components, such as a hospital, must establish separate cost entities to insure an equitable distribution of indirect costs to all cost centers. This allocation method must be approved by the Alabama Medicaid Agency and any excessive allocation to the ICF/MR facility will be disregarded.

B. Audits and Rate Computation

Description of State's Procedures for Audits - General: ICF/MR facilities will be audited by members of the audit staff of the Alabama Medicaid Agency or by an independent audit firm to ensure that reimbursement is being made only for allowable costs.

1. A desk review and analysis is made on data presented in the Uniform Cost Report. This analysis consists of a review of historical costs and an evaluation of budgeted changes. A payment rate is established based on this analysis and this payment rate is subject to modification, based on findings disclosed by a subsequent in-depth audit.

The standards, desk review, and on-site audits will be sufficient to ensure that only expense items allowable under the Alabama Plan are included in the facility's Uniform Cost Report and that the expense items included are accurately determined and attributed and are reasonable.

2. The State Agency will conduct analyses of the Uniform Cost reports by January 1st of each year of the reports submitted for the reporting year ending the previous September 30th to verify that the facility has complied with paragraphs (1) and (2) above in Section A.
3. When certain budgeted data presented in the cost report appears to be disproportionate to the historical costs or to prevailing conditions in other facilities, additional analysis or audit is performed before a rate is established.
4. An in-depth, on-site audit of each facility will be conducted as necessary. The audit standards set forth in Health Insurance Manual (HIM-18) will govern the audit procedures, along with the more specific guidelines established in the Alabama Medicaid Audit Guide for ICF/MRs. Financial records and other pertinent documents will be closely analyzed. These on-site audits will be conducted in accordance with generally accepted auditing standards and will be sufficiently comprehensive in scope to determine that only proper items of cost were included in the Uniform Cost Report and complies with paragraph (B)(1) above.
5. The on-site audits conducted in accordance with paragraph (B)(4) above shall produce an audit report, which shall meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the Uniform Cost Report includes only expense items allowable under the Alabama Plan, and that the expense items included are accurately determined and attributed, and are reasonable. These audit reports shall be kept by the State Agency for at least three years following the date of submission of such reports, and will be maintained pursuant to the record keeping and reporting requirements of the Department of Health and Human Services.
6. Subsequent to an audit of a facility, a Report of Audit will be forwarded to the facility. Certain disallowances of costs as reported on the cost report may be necessitated by the findings of the audit staff, resulting in a change of the per diem reimbursement rate. It is also possible that an audit may obviate underpayments by Medicaid to the provider, both situations resulting in the need to either recoup from or pay to the provider any over or underpayments due.
7. This settlement will be achieved in either event by a lump sum payment from the party underpaying (Alabama Medicaid

Agency) or being overpaid (the provider), and an adjustment in the per diem rate.

8. Prior to collection of any amount due the Alabama Medicaid Agency as a result of disallowances contained in the final report of audit, the facility will be given thirty (30) days to contest Medicaid's findings and to request an informal conference to present its position. Subsequent to any informal conference, an administrator who feels the results of the informal conference are adverse to his facility may request a fair hearing in writing within fifteen (15) days of Medicaid's mailing its determination on the issues presented at the informal conference. All fair hearings are conducted in accordance with Alabama Medicaid Agency rules governing fair hearings.

9. Payment rates to ICF/MRs are determined prospectively and are redetermined annually effective with rates established after the first cost reporting year.

Effective Date: 10/01/93

10. ICF/MRs will be reimbursed on a reasonable cost-related basis and payments will be based upon the lower of the facility's billing rate or maximum reimbursement rate or the facility's usual and customary charge to the general public for the same range of services minus applicable patient income. In the above statement, the billing rate is equal to the rate determined using the following methodology:

(a) Net reported costs (Schedule B, Column 5 of the cost report) shall be adjusted for cost recovery items, unallowable cost and excess administrative costs.

(b) Costs as adjusted in (a) above (less any property cost) Shall be separated into Salaries and other cost. The other cost will be multiplied by the Medicaid inflation index to calculate a budgeted increase in other expense. To determine a projected increase in salaries, the amount or % increase specified by the provider shall be used.

(c) Budgeted increases/decreases (rent, depreciation, interest, major repairs) shall be calculated using as a basis data supplied by the provider.

Effective Date: 03/01/96

(d) In lieu of depreciation for buildings and improvements, a use allowance shall be determined for governmental entities. Major movable equipment for governmental entities will be depreciated (see Appendix A).

Effective Date: 10/01/93

(e) The allowable equity capital will be multiplied by the percentage rate of return specified in Rule No.

560-X-42-.13 and the product will be the allowance for Return on Equity Capital. (This allowance applies to proprietary providers only.)

(f) The sum of the amounts as determined in (a) - (e) above shall be divided by total patient days as reported by the provider. The resulting average cost per day will be arrayed within each of the two functional groupings of facilities. The number of facilities in each grouping will be multiplied by 90% to determine the position of the facility that represents the 90th percentile. If the 90th percentile does not fall on a whole number, the Agency will round up or down to the nearest whole number. If the number falls on .0 to .49, we will round down. If the number falls on .50 or higher, we will round up. Counting from the bottom of the arrayment (upward) that facility's cost in each grouping will be the ceiling reimbursement rate for all costs of the homes within that functional class.

(g) The ICF/MR facilities are considered a separate class under the Alabama Long Term Care Program. Within this class are two groupings of facilities:

(1) Institutionally based, larger than fifteen (15) beds

(2) Institutionally based, with at least four (4), but no more than fifteen (15) beds

Within each of these facility groupings, the maximum reimbursement rate per day for a particular facility is the maximum reimbursement (as determined in (f) above) for the category in which the facility is assigned.

(h) Once the percentile ceilings have been established for a calendar year, they will be final and not normally subject to revision or adjustment during the year. Since the ceiling rates are based on information contained in the cost reports, it is to the benefit of each provider to insure that the provider's information is correct and accurate. If obvious errors are detected during the desk audit/review process, providers will be given an opportunity to submit corrected data.

(i) Finally, if a change in ownership or level of care or number of beds licensed has occurred, a facility may project the costs which are then divided by the projected total inpatient days.

(j) The monthly rate is computed by multiplying the per diem rate by 30.42 days. This rate is valid for patients in the facility for a full month. For partial month coverage, the per diem rate is multiplied times the number of days.

IV. Payment Rates Resulting from Methods and Standards

Alabama has determined that the payment rates resulting from these methods and standards are at least equal to the level which the State reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

V. Payment Assurances and Payment Limitations

A. The State will pay each provider of ICF/MR services, who furnishes the service in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan.

B. State payments made pursuant to the State Plan for ICF/MR facilities shall not exceed the general payment limits established by the United States Congress and implemented through Agency regulations, when such limits are established by the Secretary of Health and Human Services. These payments shall under no circumstances exceed the facility's customary charges to the general public for services.

C. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

D. Alabama does not adjust rates based on service deficiencies or quality of service; no payment will be made for services rendered at an inappropriate level of care.

E. Providers who participate in the program shall accept as payment in full those amounts paid to them in accordance with the State Plan.

VI. Compliance with Provisions, Methods and Standards

In order to assure compliance with its regulations, the Alabama Medicaid Agency has established certain penalties which may be assessed at its discretion, the details of which are fully set out in the Agency Administrative Code.

VII. Miscellaneous

A. The Alabama Medicaid Agency will utilize appropriate methods of notifying the public concerning proposed, substantial changes in methods and/or standards, and prior to the implementation of any substantial change in methods and/or standards, the public will have an opportunity to review and comment on the proposed changes.

B. Detailed information regarding the reimbursement methodology and related matters appears in Chapter 42 of the Alabama Medicaid Agency Administrative Code.

Addendum to B. 10.(d) (Page 16)

Depreciation will be computed using the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets. Equipment that has been amortized through a use allowance will have its remaining book value determined and that value will be depreciated over its remaining useful life. Should the remaining useful life be zero, the book value will be written off in the current year.