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STATE PLAN FOR MEDICAID PROVIDER REIMBURSEMENT

Long Term Care including Intermediate Care Facilities for the Mentally Retarded

Long-term care services and intermediate care services for the mentally retarded are paid for Medicaid recipients by means of rates determined in accordance with the following principles, methods and standards which comply 1902(a)(13)(A), and 1902(a)(30) of the Social Security Act and Federal regulations at 42 CFR 447.250 through .252, .256, .257, .272, and.280.

I Introduction:

Rate setting principles and methods are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43.

Data sources used by the Department of Health and Social Services (the Department) are the following:

1. When rebasing occurs, the Medicare Cost Report for the facility's fiscal year ending 12 months before the beginning of the year that is rebased (base year).
2. Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate in accordance with Section II, for the rate year on capital projects or acquisitions which are placed in service after the base year and for which an approved Certificate of Need has been obtained.
3. Year end reports which contain historical financial and statistical information submitted by facility's for past rate setting years.
4. Utilization and payment history report (commonly known as the MR-0-14) provided by the Division of Health Care Services.

II Allowable Costs:

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those which directly relate to Title XIX

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program recipients. Costs would include those necessary to conform with the state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible adjustments from financial statement classifications to Medicaid classifications, and may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process:

Return on investment is not an allowable cost for any facility.

Advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of only the following types of advertising and marketing is allowable:

- announcing the opening of or change of name of a facility.
- recruiting for personnel.
- advertising for the procurement or sale of items.
- obtaining bids for construction or renovation.
- advertising for a bond issue.
- informational listing of the provider in a telephone directory.
- listing a facility's hours of operation.
- advertising specifically required as a part of a facility's accreditation process.

Advocacy and lobbying expenses, along with any costs related to these activities, are not allowable.

Costs for facility-initiated court or administrative proceedings are non-allowable except when the facility prevails on the issue and the judgment doesn't include an award of fees and costs. Any allowable costs are limited to expenses incurred in the base year.

Physician compensation costs and related charges associated with providing care to patients are not allowable for purposes of calculating a prospective payment rate.

Medical services which a facility or unit of a facility is not licensed to provide are not included as an allowable cost.

Costs not authorized by a certificate of need when a certificate of need is required are not included as an allowable cost.

Pharmaceutical supplies and materials paid under other programs are not included as an allowable cost.

Management fees or home office costs which are not reasonably attributable to the management of the facility. Home office costs may not exceed those reported in the most recently Medicare audited Home Office Cost Report.

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Allowable patient related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state and federal income taxes; and interest expense. Facilities may claim a maximum of 75% of dues, meetings, conference fees, and memberships in trade organizations and associations. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments and discounts taken by payers. Base year costs and rate calculations may be adjusted for regulatory changes in allowable costs that become effective after the last adjustment for inflation.

If a certificate of need is required on assets purchased after the base year, the amount of capital costs included in the rate calculation will be limited to the amounts described within the certificate of need application and other information the facility provided as a basis for approval of the certificate of need. In determining whether capital costs exceed those amounts approved under a certificate of need, the department will consider:

- (1) the terms of issuance describing the nature and extent of the activities authorized by the certificate; and
- (2) the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

### III Inflation Adjustments:

Allowable base year costs are adjusted for inflation. Inflation adjustments may be reduced if a facility fails to timely file their year-end reports with the Department. The department will utilize the most recent quarterly publication of Global Insight's "Health Care Cost Review" available 60 days before the beginning of a facility's fiscal year. For the inflation adjustment relating to allowable non-capital costs, the department will utilize the CMS Nursing Home without Capital Market Basket. Allowable capital and allowable home office capital will be adjusted using the Skilled Nursing Facility Total Market Basket Capital Cost component.

### IV Determination of Prospective Payment Rates:

The prospective payment rate for long-term care services rendered to Medicaid recipients is a per-day rate reflecting costs related to patient care and attributable to the Medicaid program.

Prospective payment rates will be determined under one of three methodologies – Basic, Optional, and New Facilities.

a. Basic Prospective Payment Rate Methodology

The prospective payment rate consist of four components – costs excluding capital for routine cost centers, capital costs for routine cost centers, capital costs for ancillary cost centers, and costs excluding capital for ancillary cost centers. The prospective payment rates will be annual rates based on a facility's fiscal year. Except for facilities electing to be reimbursed under the optional payment rate methodology detailed in Subsection IVb, rebasing will occur for all facilities no less than every four years.

The prospective per-day rates for long-term care facilities are computed as follows:

1. Total allowable routine base year costs excluding routine capital costs for routine costs are divided by the total long-term care days. This gives the non-capital routine component of the rate.
2. Total allowable routine base year costs excluding routine non-capital costs are divided by the total long-term care days. This gives the routine capital component of the rate. Long-term care days are the greater of total actual long-term care patient days or 85% of licensed capacity days. Licensed capacity days are the product of the licensed long-term care beds in the base year multiplied by 365.
3. The ancillary capital component of the per-day payment rate is calculated by determining the percentage of capital cost for each ancillary cost center and multiplying the percentage by the related Medicaid long-term care ancillary costs from the base year. These amounts are totaled and divided by the sum of the Medicaid long-term care patient days from the base year
4. The non-capital ancillary Medicaid component of the rate is determined by subtracting Medicaid capital ancillary costs from facility Medicaid ancillary costs. This amount is then divided by facility Medicaid long-term care days from the base year. This becomes the non-capital ancillary component of the rate.

Each base year component rate is then adjusted for inflation in accordance with Section III and summed to arrive at the facility's prospective payment rate.

The capital components of the prospective payment rate will be adjusted for Certificate of Need assets placed into service, if their total value is at least \$5 million. This adjustment will reflect appropriate capital costs for the prospective year based on certificate of need documentation, assets retired in conjunction with the certificate of need, and Medicare cost reporting requirements.

For purposes of determining prospective payment rates, the Medicaid long-term care days are the covered days from payment history reports generated by the Division of Health Care Services (Subsection I4).

Prospective payment rates for facilities that are calculated and paid on a per-day basis as discussed in this Section will be no greater than the per-day rates proposed in the certificate of need application and other information provided as a basis for approval of the certificate of need for the first year during which the following are available for use and for two years immediately following the first year:

- (1) opening of a new or modified health care facility;
- (2) alteration of bed capacity; or
- (3) the implementation date of a change in offered categories of health service or bed capacity.

If a facility is granted a certificate of need with a value of at least \$5 million for additional beds, the additional capital payment add-on to the per-day rate will include the base year's long-term care days plus additional days associated with the additional beds. The additional

days are calculated as the base year's occupancy percentage multiplied by 80 percent and then multiplied by the additional beds approved in the certificate of need. The resulting figure is further multiplied by 365.

Costs are considered the lower of costs or charges in the aggregate to the general public.

b. Optional Prospective Payment Rate Methodology

A facility that had 4,000 or fewer total inpatient hospital days as a combined hospital-nursing facility or 15,000 or fewer Medicaid nursing days as a non-combined nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year may elect to be reimbursed for inpatient acute care services under provisions of this Subsection at the time of rebasing. All facilities qualifying for the Optional Payment Rate Methodology for Small Hospitals may elect to participate in the program described in this Subsection.

If a facility meets these criteria and does not elect to participate during its first fiscal year after rebasing, the facility may not reverse its decision and elect to participate under this Subsection until after a subsequent rebasing occurs under the provisions of Subsection IVa. Facilities currently participating in the program may not elect the option under this Subsection until after their current agreement expires. If a facility still qualifies to participate after their agreement expires, they may elect to do so under this Subsection.

A facility electing reimbursement by this optional methodology must have an agreement with the department that will not expire, lapse, or be revoked before four facility fiscal years have elapsed. The department will also consider if the agreement conflicts with the public concern that needy persons in the state receive uniform and high quality medical care; distribution of adequate medical services; and if appropriate appropriations are available to fund rates established under this Subsection. The agreement may be renewed after it expires if the facility still qualifies for reimbursement under this Subsection. A rebasing of the prospective payment rate for the renewed agreement will occur in accordance with Subsection IVa.

The prospective payment rate will be determined as follows:

- (1) The prospective payment rate is expressed as a per-day rate, composed of separate capital and non-capital components.

(2) For the first year of the agreement, the capital component is calculated as described in Subsection IVa. The resulting amount is adjusted for inflation at 1.1 percent per year for each fiscal year after the first year of election until the agreement expires.

(3) For the first year of the agreement, the non-capital component is calculated as described in Subsection IVa. The resulting amount is adjusted for inflation at three percent per year for each fiscal year after the first year of election until the agreement expires.

For state fiscal years 2016 and 2017, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

Increases in the capital component of the prospective payment rate for new assets placed in service during the period covered by the agreement will be allowed, based on the provisions in Subsection IVa, if the following conditions are met:

- 1) The assets placed into service have a value of at least \$5,000,000;
- 2) The facility obtains one or more Certificates of Need for the assets placed into service; and
- 3) The facility provides a detailed budget that reflects the allowance for the new assets before the prospective payment rate is increased.

In most cases, a facility must use the “exceptional relief” process for appealing department decisions pursuant to Subsection XII. The administrative appeals process outlined in Subsection VIII, will be used only when an appeal relates to one of the following subjects:

- 1) The facility’s eligibility to elect rate setting under this Subsection;
- 2) The violation of a term of the rate agreement between the facility and the department;
- 3) The denial of an increase in the capital component of the prospective payment rate for new assets related to an approved Certificate of Need.

A small facility acute care hospital may elect a new four-year rate agreement as described in this Subsection if the facility becomes a combined acute care hospital-nursing facility. The facility may choose this option within 30 days after the combination of the two facilities. The nursing facility payment rate is calculated as follows:

- the nursing facility per-day rate is the statewide weighted average of the payment rates in effect for small facility nursing homes qualifying under this Subsection on the date the facilities combine;

A rate agreement made under this Subsection may be renewed if the small facility still qualifies under this Subsection. The department will perform a rebasing in accordance with Subsection IVa at the time rate agreements are renewed.

c. New Facility Prospective Payment Rate Methodology

If a new long-term care facility is licensed, the will be the sum of:

1. The swing-bed rate in effect at the start of the facility's rate year, less the average capital cost contained in the swing-bed rate.
2. Capital costs as identified by the facility subject to the limitations as described in Section II, using the greater of occupancy rates approved in the certificate of need or 80% of licensed beds.

Rates for a new facility will be established under Subsection IVa after two full fiscal years of cost data is reported.

V. Sale of Facilities:

For facilities acquired on or after October 1, 1985, the increase in the depreciable base is limited to one-half of the percentage increase since the date of the sellers acquisition, in the Dodge Construction Systems Costs Index for Nursing Homes, or, one-half of the percentage increase in the consumer price index for all urban consumers, whichever is less. All related operating costs including interest are limited to the allowable changes in asset base. No facilities were sold or acquired between 1982 and October 1, 1985.

In addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of 42 CFR 447.253(d) of the Code. Payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of 42 CFR 447.253 (d) of the Code.

Example of Purchase Limitations

Historical Costs

Book Value	\$5,000,000
Accumulated Depreciation	<u>2,500,000</u>
Net Book Value	\$2,500,000
Annual Depreciation	\$ 200,000
Long Term Debt	\$1,000,000
Interest on Debt	\$ 100,000
Allowable Costs	<u>\$ 300,000</u>
Purchase Price	\$8,000,000
Depreciation	\$ 400,000
Long Term Debt	\$6,000,000
Interest on Debt	\$ 600,000
Operating Costs	<u>\$1,000,000</u>
Change in CPI (Since original acquisition)	25%
Dodge Index	35%
Allowable change 25% divided by 2 = 12.5%	
New Depreciable Base	\$5,600,000
Accumulated Depreciation	<u>2,800,000</u>
Net Value	\$2,800,000
Depreciation	\$ 224,000
Allowable Interest Based on 40% debt prior to purchase on net value at historical 10% rate (\$2,800,000 X 40% X 10%)	<u>\$ 112,000</u>
Allowable Costs	\$ 336,000

Note: The example is simplified for presentation. Original investment was assumed to be made at one time. There are no loan costs or start up costs factored in the original purchase or subsequent purchase.

VI. (Reserved)

VII. Adjustment to Rates:

Rates for facilities are set by the Department. Facilities have the opportunity to provide additional information on significant changes that would impact the rates.

The Department, on its own or at the request of an applicant, in its discretion, will reconsider its actions within 30 days. There is nothing to preclude a facility from petitioning the department at any time during its fiscal year for additional consideration.

Reconsiderations are warranted only in those cases where the proper application of the methods and standards described in Attachment 4.19-D is in question or is being challenged.

VIII. Provider Appeals:

If a party feels aggrieved as a result of the department's rate setting decisions, the party may appeal and request reconsideration or an administrative hearing.

Administrative hearings are conducted by Governor appointed Hearing Officers. An administrative appeal must be filed within 30 days of the mailing of the decision of the Department.

The Hearing Officer would hear a case in accordance with administrative law in the state of Alaska. The Hearing Officer would prepare draft findings, conclusions and order for the Commissioner of the Department's review. The Commissioner of the Department would review the findings of the Hearing Officer and may accept, reject, or modify the Hearing Officer's recommendations. If the party still feels aggrieved at this point, judicial review is available to contest actions of the Department and the rate set.

**IX. Audit Function:**

The Department has statutory authority to audit data relating to Medicaid prospective payment rates. Audit findings that would affect prospective payment rates are adopted by the department and incorporated into future prospective rate calculations.

**X. Exceptional Relief to Rate Setting:**

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the Deputy Commissioner of the Department for exceptional relief from the rate setting methodology.

This provision applies to situations where a facility is forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

- 1 the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;
2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;
3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;
4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;

- expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;
5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;
  6. an analysis of community needs for the service on which the exception request is based;
  7. a detailed analysis of the options of the facility if the exception is denied;
  8. an analysis of how Medicaid patients will lose access to Medicaid services available to the general public in the same geographic area if exceptional relief is not granted.
  9. a plan or future action to respond to the problem; and
  10. any other information requested by the deputy commissioner to evaluate the request.

The Deputy Commissioner may increase the rate, by all or part of the facility's request if the Deputy Commissioner finds by clear and convincing evidence that the rate established under Section IV. and Section VI. of Attachment 4.19-D does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the Deputy Commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;
2. the assessment of continued need for this facility's services in the community;
3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;
4. (Reserved)
5. the availability of other resources available to the facility to respond to the crisis;

The Deputy Commissioner may impose conditions on the receipt of exceptional relief including, but not limited to the following:

- 1 the facility sharing the cost of the rate exception granted;
- 2 the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;
- 3 the facility providing documentation as specified of the continued need for the exception; or
- 4 a maximum amount of exceptional relief to be granted to the facility under this section.

If the Deputy Commissioner finds by clear and convincing evidence that the rate established under the methodology does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest, the Deputy Commissioner may, in his or her sole discretion increase the rate.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the Deputy Commissioner concerning exceptional relief may request an administrative hearing to the Commissioner of the Department.

**XI. Public Process**

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.