DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

OFFICIAL FILE COPY

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 7 0 0 9

2. STATE: Alaska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1997

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 - .280

7. FEDERAL BUDGET IMPACT:
a. FFY 97 $ 24,765,005
b. FFY 98 $ 25,833,435

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 D

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19 D
pages 1 - 20

10. SUBJECT OF AMENDMENT:
Long Term Care Facility Rates

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
For Bob Labbe

14. TITLE:
Director, Div. of Medical Assistance

15. DATE SUBMITTED:
Sept. 30, 1997

16. RETURN TO:
Division of Medical Assistance
PO Box 110660
Juneau, AK 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
OCT - 3 1997

18. DATE APPROVED:
April 19, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 1997

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Teresa L. Trimble

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:
POSTMARKED: 9/30 (DATE) Juneau AK (CITY/STATE)

FORM HCFA-179 (07-92)

Instructions on Back

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Associate Regional Administrator

23. REMARKS:

"POSTMARKED: 9/30 (DATE) " Juneau AK (CITY/STATE)

FORM HCFA-179 (07-92)

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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 with 42 CFR 447.250 through 477.272. Assurances, findings and related information required by 42 CFR 447.253 and 447.255 have been transmitted separately and are not included in the description of the following payment methodology.

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 Medicaid Rate Advisory Commission (Commission) and the Department of Health and Social Services (Department) are the following:

1. Medicare Cost Reports for the facility's fiscal year ending 24 months before the beginning of the facility's prospective rate 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 beginning of the base year and before the end of the rate year and for which an approved CON (Certificate of Need) has been obtained.

   A CON is required for certain expenditures of $1,000,000 or more. Some situations requiring a CON include major alterations or additions to buildings, any addition or elimination of a major type of care in or through a facility, and any change in licensed beds within a two year period amounting to 10 beds or 10 percent of total beds.

3. Operating budgets, as applicable, submitted by new Medicaid providers.

4. Historical financial and statistical information submitted by facilities for past rate setting years.

5. Utilization and payment history provided by the Division of Medical Assistance.

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 program recipients. They are costs which must be incurred by an efficiently and economically operated provider. 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 part of a facility's accreditation process.

* nursing staff in a long-term care facility is allowable as a routine cost only.

* physician compensation costs and charges associated with providing care to patients are not included as an allowable cost.

* medical services which 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 allowable costs.

* 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 a facility.

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, interest expense. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific nonallowed costs are bad debts, charity, contractual adjustments and discounts taken by payers.

A Certificate of Need is required for certain expenditures of $1,000,000 or more. Situations requiring a CON include major alterations or additions to buildings, any addition or elimination of a major type of care in or through a facility, and any change in licensed beds within a two year period amounting to 10 beds or 10 percent of total beds. If a certificate of need is required on assets purchased after July 1, 1990, 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. In determining whether capital costs exceed those amounts approved under a certificate of need, and for determining the maximum prospective per diem rate 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 costs are determined by adjusting base year data. Base year data will be the allowable operating costs excluding capital costs in the facility's fiscal year ending 24 months before the prospective rate year. For example, facilities whose fiscal year began July 1, 1997, the most current or fiscal year would be the fiscal year beginning July 1, 1994. The allowable base year costs are adjusted for inflation. Inflation is calculated annually using projected inflation indices developed based on data available in May prior to the facility's fiscal year beginning.

Substantial amounts of different economic and inflationary data sources are utilized to arrive at the most accurate Alaska inflationary factor possible. National inflation projections and economic trends such as those published by Data Resources, Incorporated and ACCRA (cost of living index) are utilized. Regional inflationary data that the Department has available is given consideration during the evaluation of inflation rates to be set. In addition to the published economic and inflationary reports considered in the analysis, the Department also considers recommendations of the Medicaid Rate Advisory Commission in the development of the inflation factors. Inflation is projected on a compound rate over a three year period of time. Inflation forecasts are developed based on anticipated changes in inflation using a HCFA type market basket.

The inflation factors applied to the long-term care services are as follows:

The three year average compounded inflation rate will be 7.2%.

Inflation rates for the following years will be used:

1996	2.1%
1997	2.4%
1998	2.5%

Compounding of inflation factors create a situation where the total is greater than the three years inflation factors. The adjustment then allows the inflation factors to be used independently. This results in allowable increases of costs attributed to inflation between 1996 and 1998 of 7.2%.

IV. Determination of Payment Rates:

The prospective payment rate for long-term care facilities is a single per diem rate with identified base capital and acquisitions which are placed in service after the beginning of the base year and before the end of the rate year and for which an approved CON has been obtained, routine and ancillary components. Ancillary costs include physician