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CHAPTER FIFTY-SEVEN

HOME- AND COMMUNITY-BASED SERVICES
FOR THE STATE OF ALABAMA INDEPENDENT LIVING (SAIL) WAIVER

Chapter 57. Home and Community-Based Services for the State of Alabama Independent Living (SAIL) Waiver.

Rule No. 560-X-57-.01. Authority and Purpose.

(1) Home and community-based services for the SAIL Waiver are provided by the Alabama Medicaid Agency to disabled individuals who would otherwise require institutionalization in a nursing facility. These services are provided through a Medicaid waiver under the provisions of Section 1915(c) of the Social Security Act for an initial period of three years and for five year periods thereafter upon renewal of the waiver by the Centers for Medicare and Medicaid Services.

(2) The purpose of providing home and community-based services to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care.

Author: Patricia A. Harris, Administrator, LTC Program Management Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 CFR 441, Subpart G.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-57-.02. Eligibility.

(1) Financial eligibility is limited to those individuals receiving SSI, individuals receiving State Supplementation, SSI related protected groups deemed to be eligible for SSI/Medicaid, and Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate.

(2) Medical eligibility is determined based on current admission criteria for nursing facility level of care as described in Rule No. 560-X-10-.10.

(3) No waiver services will be provided to recipients in a hospital or nursing facility. However, case management activities are available to assist recipients interested in transitioning from an institution into a community setting. Case management activities to facilitate the transition are limited to a maximum of 180 days prior to discharge into the community.

(4) The Alabama Medicaid Agency or its operating agency, Alabama Department of Rehabilitation Services, acting on Medicaid's behalf may deny home and community-based services if it is determined that an individual's health and safety is at risk in the community; if the cost of serving an individual on the waiver exceeds the cost of caring for that individual in a nursing facility; if the individual does not cooperate with a provider in the provision of services; or if an individual does not meet the goals and objectives of being on the waiver program.

(5) The Alabama Medicaid Agency is restricted by the waiver to serving the estimated annual unduplicated number of beneficiaries approved by the Centers for Medicare and Medicaid Services.

(6) The eligibility age criteria is 18 years and above.

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based SAIL Waiver.
History: Rule effective June 12, 1992. Effective date of this amendment is February 10, 1994. Effective date of this amendment is October 12, 1996. **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.

Rule No. 560-X-57-.03. Operating Agencies

The Home and Community-Based SAIL Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Rehabilitation Services.

Author: Patricia A. Harris, Administrator, LTC Program Management Unit
Statutory Authority: The Home and Community-Based Homebound Waiver.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-57-.04. Covered Services.

(1) Case Management Services.

(a) Case management is a system of providing services which will assist waiver recipients in gaining needed waiver and other state plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. Case management services may be used to locate, coordinate, and monitor necessary and appropriate services. Case management activities may also be used to assist in the transition of an individual from institutional settings prior to discharge into the community.

(b) Case managers are responsible for care plan development and ongoing monitoring of the provision of waiver services and nonwaiver services included in the recipient's care plan.

(c) Case management will be provided by a case manager employed by or under contract with the Department of Rehabilitation Services or any other Medicaid approved provider of waiver services that meets the qualifications of Nurse I or Rehabilitation Counselor.

(2) Personal Care Services.

(a) Personal care services are services that provide assistance with eating, bathing, dressing, personal hygiene and activities of daily living. Services may include assistance with preparation of meals but do not include the cost of meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

(b) Personal care services will be provided by individuals employed by a certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency and supervised by a case manager. Persons providing personal care services must meet the qualifications of a personal care attendant and meet provider performance standards.

(c) Personal care services may be provided by family members or friends only if lack of other qualified providers in applicable remote areas exists. Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child or to a recipient's spouse if qualified providers are in the area. Payment will not be made for services furnished to a recipient by their child, the recipient's spouse or to a minor by a parent (or stepparent).

(d) Services provided to each client are dependent on individual need as set forth in the client's plan of care. Personal care services may not exceed 25 hours per week and may not exceed 1300 hours per waiver year (April 1 – March 31). Medicaid will not reimburse for activities which are not within the Scope of Services.

(3) Environmental Accessibility Adaptations

(a) Environmental accessibility adaptations provide those physical adaptations to the home required by the individual's plan of care which are necessary to ensure the health, welfare, and safety of the individual or which enable the individual to function with greater independence in the home and without which the individual would require institutionalization. The service may also be provided to assist an individual to transition from an institution to the SAIL Waiver, but should not be billed until the first day the client is active on the waiver. Adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as floor covering, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home or permanent adaptations to rental property are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

(b) Environmental accessibility adaptations will be provided by individuals capable of constructing or installing the needed apparatus. Any construction/installation completed must be in accordance with state and local building codes.

(c) Environmental accessibility adaptations must be prior authorized and approved by the Alabama Medicaid Agency or its designee for prior authorization and

must be listed on the client's plan of care. Any expenditure in excess of the maximum allowed amount must be approved by the State Coordinator and the Medicaid designated personnel.

(4) Personal Emergency Response System.

(a) Personal Emergency Response System (PERS) is an electronic service which enables certain high-risk patients to secure help in the event of an emergency. The client may also wear a portable "help" button which will allow for mobility. The system is connected to a patient's phone and programmed to signal a response center once a patient's "help" button is activated.

(b) PERS must be provided by trained professionals. The PERS staff must complete a two-week training period for familiarization with the monitoring system and proper protocol to provide appropriate response action.

(c) Initial setup and installation of PERS must be on the individual's plan of care, prior authorized and approved by the Alabama Medicaid Agency or its designee.

(5) Medical Supplies.

(a) Medical supplies include devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, or to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

(b) Providers of this service will be only those who have signed provider agreements with the Alabama Medicaid Agency and the Department of Rehabilitation Services.

(c) Medical supplies service shall not exceed $1,800.00 annually per recipient.

(6) Minor Assistive Technology

(a) Minor Assistive Technology (MAT) includes supplies, devices, controls or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. Minor Assistive Technology is necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition.

(b) Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency and the Department of Rehabilitation Services. Vendors providing MAT/devices should be capable of supplying and providing training in the use of the minor assistive technology/device.

(c) MAT shall not exceed the designated amount of $500.00 per recipient per waiver year.

(7) Assistive Technology.

(a) Assistive technology includes devices, pieces of equipment or products that are modified or customized which are used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an assistive technology device. Such services may include evaluation of need, acquisition, selection, design, fitting, customizing, adaptation, application, etc. This service must be listed on the individual's care plan. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. The service must be medically necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the SAIL Waiver. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate. All items shall meet applicable standards of manufacture, design and installation.

(b) Assistive technology and transitional assistive technology services must be prior authorized and approved by the Alabama Medicaid Agency, or its designee and must be listed on the client's plan of care.

(c) Assistive technology services will be provided by licensed individuals or businesses capable of supplying the needed equipment and/or supplies. Assistive technology must be approved by the Alabama Medicaid Agency and must be listed in the individual's plan of care. Providers of this service will be those who meet provider qualifications and who have a signed provider agreement with the Alabama Department of Rehabilitation Services. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.

(8) Assistive Technology Repairs

(a) Assistive technology repairs will provide for the repair of devices, equipment, or products that were previously purchased by the Alabama Medicaid Agency for the recipient. Repairs include replacement of parts or batteries to allow the equipment to operate.

(b) The provider should be responsible for replacement or repair of the equipment or any part thereof that is found to be nonfunctional because of faulty material or workmanship within the guarantee of the manufacturer without any charge to the recipient or the Alabama Department of Rehabilitation Services. Repairs outside the warranty period will be reimbursed by the operating agency.

(c) Businesses providing this service will possess a business license and also be required to give a guarantee on work performed.

(d) This service must be listed on the recipient Plan of Care before being provided.

(e) The maximum amount for this service is $2000.00 per recipient annually.

(9) Evaluation for Assistive Technology

(a) Evaluation for assistive technology will provide evaluations and determinations of a client's needs for equipment prescribed by a physician to promote health, safety, and prevent institutionalization or to assist an individual to transition from

an institutional level of care to the SAIL Waiver. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

(b) The individual providing evaluation must be a physical therapist licensed to do business in the State of Alabama and enrolled as a provider with the Alabama Department of Rehabilitation Services. The physical therapist should not have any financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of assistive technology equipment/devices.

(c) A written copy of the physical therapist's evaluation must accompany the prior authorization request and a copy must be kept in the recipient's file. This service must be listed on the recipient's Plan of Care before being provided.

(10) Personal Assistance Service

(a) Personal assistance services (PAS) are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. These activities would be performed by the individual if that person did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform everyday activities. This service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those seeking competitive employment either in their home or in an integrated work setting.

(b) Personal assistance services will be provided by a personal care attendant under the supervision of a registered nurse who meets the Personal Assistance Service staffing requirements. Individuals providing personal care services must meet the qualifications of a personal care attendant and meet provider performance standards.

(c) Personal assistance services may be provided by family members or friends only if lack of other qualified providers in remote areas exists. Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child or to a recipient's spouse if qualified providers are in the area. Payment will not be made for services furnished to a recipient by their child, the recipient's spouse or to a minor by a parent (or stepparent).

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based SAIL Waiver.
History: Rule effective June 12, 1992. Amended February 19, 1994; October 12, 1996. **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 September 20, 2007; effective December 14, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008. **Amended:** Filed March 20, 2009; effective June 16, 2009.

Rule No. 560-X-57-.05. Costs for Services.

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total

expenditures that would be incurred for such individuals if home and community-based services were not available.

Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Homebound Waiver. Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992.

Rule No. 560-X-57-.06. Application Process.

(1) The case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community based services. For institutional residents residing in a facility for at least 90 days who are interested in transitioning into the community, the case manager should thoroughly review referrals and intake information. This process will take place during the 180 consecutive day transition period.

(2) An initial assessment will be completed by the case manager in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the operating agency, Alabama Department of Rehabilitation Services (ADRS), for approval.

(3) The case manager, in conjunction with the applicant's physician, client and/or caregiver will develop a Plan of Care. The Plan of Care will include objectives, services, provider of services, and frequency of service. Changes to the original Plan of Care are to be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's care plan which is subject to the review of the Alabama Medicaid Agency. The Plan of Care must be reviewed by the case manager as often as necessary and administered in coordination with the recipient's physician.

(4) The Alabama Medicaid Agency has delegated the medical level of care determination to qualified trained individuals at ADRS.

(5) Medicaid requires the providers to submit an application in order to document dates of service provision to long term care recipients.

(a) The long term care file maintains these dates of service.

(b) The applications will be automatically approved through systematic programming.

(c) The Alabama Medicaid Agency will perform random audits on a percentage of records to ensure that documentation supports the medical level of care criteria, physician certification, as well as other state and federal requirements.

(6) ADRS is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community-based services in accordance with the provisions of the SAIL Waiver.

(7) The Alabama Medicaid Agency will provide to ADRS the approved Level of Care criteria and policies and procedures governing the level of care determination process.

(8) ADRS will designate a qualified medical professional to approve the level of care and develop the Plan of Care.

(9) Admissions, readmissions and annual redeterminations must be certified by a physician licensed to practice in Alabama.

(10) ADRS may utilize Medicaid staff for consultation on questionable admissions and annual redeterminations prior to a final decision being rendered.

(11) The Alabama Medicaid Agency will conduct a monthly retrospective review of a random sample of individuals served under the SAIL Waiver to determine appropriate admissions and annual redeterminations. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

(12) The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal, medical necessity, and eligibility requirements are not met.

(13) The Alabama Medicaid Agency may seek recoupment from ADRS for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for SAIL Waiver services or Medicaid eligibility but for the certification of waiver eligibility by ADRS.

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the SAIL Waiver.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed May 20, 2003; effective August 21, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-57-.07. Financial Accountability of Operating Agency.

(1) The financial accountability of the operating agency for funds expended on Home and Community-Based services must be maintained and provide a clearly defined audit trail. The operating agency as described in the waiver document must retain records that fully disclose the extent and cost of services provided to eligible recipients for a five-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available

within the state of Alabama, the operating agency will pay the travel cost of the auditors to the location of the records.

(2) The operating agency may have their records audited annually at the discretion of the Alabama Medicaid Agency. Payments that exceed actual allowable cost will be recovered by Medicaid.

(3) The Alabama Medicaid Agency will review at least annually recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

(4) The operating agency will provide documentation of actual costs of services and administration. Such documentation will be entitled "Quarterly Cost Report" for the SAIL Waiver. The "Quarterly Cost Report" will include all actual costs incurred by the operating agency for the previous quarter and include costs incurred year to date. This document will be submitted to the Alabama Medicaid Agency before the 1st day of the third month of the next quarter. Quarters are defined as follows:

(a) 1st April -June
Due before September 1

(b) 2nd July-September
Due before December 1

(c) 3rd October-December
Due before March 1

(d) 4th January-March
Due before June 1

Failure to submit the actual cost documentation may result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed. Quarterly cost reports will be reviewed to determine necessity for a field audit.

(5) Auditing Standards - Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State and Local Governments" will apply to governmental agencies participating in this program. For non-governmental agencies, generally accepted accounting principles will apply. Governmental and non-governmental agencies will utilize the accrual method of accounting unless otherwise authorized by the Alabama Medicaid Agency.

(6) Cost, Allowable and Unallowable.

(a) 45 C.F.R., part 95, specifies dollar limits and accounting principles for the purchase of equipment. Purchases above the twenty-five thousand dollar limit require the approval of Medicaid.

(b) OMB Circular A-87 establishes cost principles for governmental agencies and will serve as a guide for non-governmental agencies. For governmental agencies, all reported cost will be adjusted to actual cost at the end of the waiver year.

(c) Contract payments for the delivery of specific services are allowable expenses. Thus, contracts for case management, personal care, respite care, environmental accessibility adaptations, assistive technology, and medical supplies are recognized expenses. All other contracts will require Medicaid approval to insure that functions are not being duplicated. For example, outreach is to be performed by the case manager, thus, it would not be appropriate to approve other contracts for outreach, unless it can be clearly shown that the function is required and cannot be provided within the established organization.

(d) Allowable costs are defined in OMB Circular A-87. However, the following restrictions apply:

1. Advertising is recognized only for recruitment of personnel, solicitation of bids for services or goods, and disposal of scrap or surplus. The cost must be reasonable and appropriate.

2. The cost of buildings and equipment is recognized. For governmental agencies, buildings and equipment exceeding twenty-five thousand dollars will be capitalized in accordance with 45 C.F.R. 95.705 and depreciated through a use allowance of two percent of acquisition cost for building and six and two-thirds percent for equipment. Equipment that has a remaining value at the completion of the project will be accounted for in accordance with 45 C.F.R. 95.707. For automated data processing equipment, see 45 C.F.R. 95.641. When approval is required, the request will be made to Medicaid Agency in writing.

3. The acquisition of transportation equipment will require prior approval from the Alabama Medicaid Agency. When approval is required, the request will be made to Medicaid in writing.

4. Transportation is an allowable expense to be reimbursed as follows:

(i) For non-governmental agencies, it will be considered as part of the contract rate.

(ii) For government and private automobiles utilized by state employees, reimbursement will be made at no more than the current approved state rate.

(iii) All other types of transportation cost will be supported by documents authorizing the travel and validating the payment.

(e) Unallowable costs are specified in OMB Circular A-87. In addition to these, the following are not covered by this program:

1. Costs covered by other programs, such as:

(i) Prescription drugs,

(ii) Dental expenses,

(iii) Ambulance service,

(iv) Inhalation, group, speech, occupational, and physical therapy.

(v) Non-emergency transportation

2. The cost of advisory councils or consultants without Alabama Medicaid Agency's approval.

3. Legal fees as follows:

(i) Retainers,

(ii) Relating to fair hearings,

(iii) In connection with law suits, which result in an adverse decision,

(iv) Services that duplicate functions performed by Medicaid or the provider, such as eligibility determination for the program,

(v) Other legal fees not relating to the providing of services to the beneficiaries.

4. Dues and subscriptions not related to the specific services.

(7) Cost Allocation Plans.

(a) State agencies are required to have a cost allocation plan approved by the Division of Cost Allocation (DCA) when the agencies handle multiple federal funds. The format of a cost allocation plan is specified by 45 C.F.R. 95.507, which also calls for written agreements between state agencies. Existence of such a plan will be an item of audit.

(b) Direct costs are charged to the specific services that incurred them. It is the indirect/overhead costs that are allocated to the specific fund. If there is more than one project within a fund, there must be a written plan to distribute fund costs among the projects. Within this project, there are two types of indirect costs. The first are those that can be associated with the services that are provided, such as an assessment at the central office that verifies the quality of service. This cost can be prorated to each service by some method that is described in writing. This first type of cost qualifies for the federal match benefit percentage.

The second type of allocated cost falls under the administration definition. For example, a case manager that spends time on two individuals (or group of people) that have not attained waiver eligibility. This second type has a federal match of 50/50; therefore, both types must be accounted for separately.

(c) Contracts which are used for procuring services from other governmental agencies must be cost-allocated. As a minimum, these contracts should meet the requirements of 45 C.F.R. 95.507; these contracts must indicate:

1. The specific services being purchased.

2. The basis upon which the billing will be made -- (e.q., time reports, number of homes inspected, etc.).

3. A stipulation that the billing will be based on actual costs incurred. This is not a requirement for non-governmental agencies. For governmental agencies, the billing should be either actual cost or an agreed upon fixed fee approximating actual cost which will be adjusted to actual cost at completion of the waiver year.

Author: Sigrid Laney, Associate Director, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the SAIL Waiver.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of the amendment is October 12, 1996. **Amended:** Filed April 21,

2003; effective July 16, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007.

Rule No. 560-X-57.-08. Fair Hearings.

(1) An individual whose application to the Waiver Program is denied based on financial eligibility may request a hearing through the appropriate certifying agency.

(2) An individual who is denied home and community-based services based on medical criteria, may request a fair hearing through the Alabama Medicaid Agency, Long Term Care Division.

Author: Patricia A. Harris, Administrator, LTC Program Management Unit.
Statutory Authority: 42 CFR Section 431, Subpart E.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-57.-09. Appeal Procedure for Medicaid Fiscal Audits.

(1) Fiscal audits of the SAIL Waiver Services are conducted by the Provider Audit Division of Medicaid. At the completion of the field audit there will be an exit conference with the operating agency to explain the audit findings. The operating agency will have the opportunity to express agreement or disagreement with the findings. The field audit and the comments of the operating agency are reviewed by the Associate Director of the Provider Audit Division and a letter is prepared making the appropriate findings official. If the operating agency deems that the findings are not justified, they may request an informal conference with the Director of the Provider Audit Division.

To request the informal conference, the operating agency must submit a letter within thirty days from the date of the official audit letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to:

ATTN: Director
Provider Audit Division
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

The decisions of the Director, Provider Audit Division made as a result of the informal conference will be forwarded to the operating agency by letter. If the operating agency believes that the results of the informal conference are still adverse, they will have 15 days from the date of the letter to request a fair hearing.

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 431, Subpart E.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

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.

(3) 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.

(4) 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.

(5) 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.

(6) 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: Latonda Cunningham, Administrator, LTC Project Development/Program Support 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.

Rule No. 560-X-57-11. Third Party Liability.

(1) The Third Party Division, Alabama Medicaid Agency, is responsible for fulfilling the requirements pertaining to third party liability. The purpose of the Third Party Division is to insure that Medicaid is the last payor. Providers shall make all reasonable efforts to determine if there is a liable third party source, including Medicare, and in the case of a liable third party source, utilize that source for payments. Third party payments received after billing Medicaid for service for a Medicaid recipient shall be refunded to the Alabama Medicaid Agency within sixty days of receipt of Medicaid payment. For further information concerning Third Party Liability refer to Administrative Code Chapter 20.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Sections 22-6-6 of 1975 Code of Alabama. Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992.

Rule No. 560-X-57-.12 Confidentiality

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon written consent of the recipient, his or her attorney, and/or guardian, or upon subpoena from a court of appropriate jurisdiction.

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 431.306.
History: New Rule: Filed April 21, 2003; effective July 16, 2003.