

TABLE OF CONTENTS

CHAPTER THIRTY-SIX

HOME- AND COMMUNITY-BASED SERVICES
FOR THE ELDERLY AND DISABLED

RULE	TITLE	PAGE
560-X-36-.01	Authority and Purpose	1
560-X-36-.02	Eligibility	1
560-X-36-.03	Operating Agencies	2
560-X-36-.04	Covered Services	2
560-X-36-.05	Costs for Services	6
560-X-36-.06	Application Process	6
560-X-36-.07	Financial Accountability of Operating Agencies	8
560-X-36-.08	Fair Hearings	11
560-X-36-.09	Payment Methodology for Covered Services	12
560-X-36-.10	Confidentiality	13
560-X-36-.11	Appeal Procedure for Fiscal Audit	13
560-X-36-.12	Third Party Liability	14

Chapter 36. Home-and Community-Based Services for the Elderly and Disabled.

Rule No. 560-X-36-.01. Authority and Purpose.

(1) Home- and community-based services to the elderly and disabled are provided by the Alabama Medicaid Agency to categorically needy 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 waiver by the Centers for Medicare and Medicaid Services (CMS). Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan.

(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. Waiver services are not entitlements but are based on individual client needs. The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers enrolled for each service included in his or her written plan of care.

(3) Waiver services provided to eligible Medicaid recipients must be identified on the individual's Plan of Care and the Service Authorization Form. Waiver services provided but not listed on the Plan of Care and the Services Authorization Form are not reimbursable. Payments rendered for services not present on the Plan of Care and the Service Authorization Form will be recovered.

(4) It is not the intent of the E/D Waiver Services program to provide 24 hour in home care. Should 24 hour in home care become necessary in order to protect the health and safety of the waiver client, the appropriateness of waiver services should be assessed and other alternatives considered.

Author: Patricia Harris, Administrator, LTC Program Management Unit

Statutory Authority: Section 1915(c) Social Security Act; 42 C.F.R. Section 441, Subpart G.

History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, and May 15, 1990. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-36-.02. Eligibility.

(1) Financial eligibility is limited to those individuals receiving SSI, individuals deemed to be receiving SSI, the optional categorically needy at a special income level of 300 percent of the Federal Benefit Rate (FBR) who are receiving HCBS waiver services, individuals receiving State Supplementation, and individuals receiving State or Federal Adoption Subsidies.

(2) Medical eligibility is determined based on current admission criteria for nursing facility 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. Discharge planning by a case manager is a reimbursable service.

(4) The Alabama Medicaid Agency or its operating agencies acting on Medicaid's behalf may also 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 CMS.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit

Statutory Authority: 42 CFR Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled.

History: Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed July 20, 2005; effective October 14, 2005. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-36-.03. Operating Agencies.

The Home- and Community-Based Waiver for the Elderly and Disabled is a cooperative effort among the Alabama Medicaid Agency, and the state agencies as specified in the approved waiver document. The State affirms that it will abide by all terms and conditions set forth in the waiver.

Author: Patricia Harris, Administrator, LTC Program Management Unit

Statutory Authority: The Home- and Community-Based Waiver for the Elderly and Disabled.

History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-36-.04. Covered Services.

(1) Case Management Services.

(a) Case management is a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or

organization. A case manager is responsible for outreach, intake and referral, diagnosis and evaluation, assessment, care plan development, and implementing and tracking services to an individual. All E/D waiver recipients will receive case management services.

(b) Case Management must be on the Plan of Care as a waiver service. Waiver services not listed on the Plan of Care and the Service Authorization Form will not be paid. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(c) Case management will be provided by a case manager employed by or under contract with the state agencies as specified in the approved waiver document. The case manager must meet the qualifications as specified in the approved waiver document.

(2) Homemaker Services.

(a) Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning, and personal services. They are provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for the recipient.

(b) A person providing homemaker services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(3) Personal Care Services.

(a) Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, reminding client to take medications, and securing health care from appropriate sources.

(b) A person providing personal care services must be employed by a certified Home Health Agency or other agency approved by the Alabama Medicaid Agency and supervised by a licensed nurse, and meet the qualifications of a Personal Care Attendant as specified in the approved waiver document. This person may not be a relative, as defined by CMS, of the recipient.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services furnished by a member of the recipient's family.

(e) No payment will be made for services not listed on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(4) Adult Day Health Services.

(a) Adult Day Health Service provides social and health care in a community facility approved to provide such care. Health education, self-care training, therapeutic activities, and health screening shall be included in the program.

(b) Adult Day Health is provided by facilities that meet the minimum standards for Adult Day Health Centers as described in Appendix C of the Home and Community-Based Waiver for the Elderly and Disabled. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health meets the prescribed standards.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services not listed on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(5) Respite Care.

(a) Respite care is given to individuals unable to care for themselves on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care is provided in the individual's home and includes supervision, companionship and personal care of the individual. Respite is intended to supplement not replace care provided to waiver clients. Respite is not an entitlement. It is based on the needs of the individual client and the care provided by the primary caregiver.

(b) Respite care may be provided by a companion/sitter, personal care attendant, home health aide, homemaker, LPN or RN, depending upon the care needs of the individual. All other waiver services except case management will be discontinued during the in-home respite period.

(c) Payment will not be made for respite care furnished by a member of the recipient's family; may not exceed 720 hours or 30 days per waiver year (October 1 through September 30); must not be used to provide continuous care while the primary caregiver is employed or attending school.

(d) Medicaid will not reimburse for activities performed which are not within the scope of services.

(e) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(6) Companion Services:

(a) Companion service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as: activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client.

(b) Other service definitions include accompanying a client to a medical appointment, grocery shopping or picking up prescription medications. The companion service is available to only those clients living alone. Companion services cannot be provided at the same time as other approved waiver services with the exception of case management services. Companion services must not exceed four (4) hours daily. Payment will not be made for companion services furnished by a member of the recipient's family.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) Companion service is not an entitlement. It is based on the needs of the individual client.

(e) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the Plan of Care shall be recovered.

(7) Home Delivered Meals

(a) Home delivered meals are provided to an eligible individual age 21 or older who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home-delivered meals.

(b) This service will provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability/dependency and who require nutritional assistance to remain in the community, and do not have a caregiver available to prepare a meal for them.

(c) This service will be provided as specified in the care plan and may include seven (7) or fourteen (14) frozen meals per week. Clients will be authorized to receive one (1) unit of service per week. One unit of service is a 7-pack of frozen meals. Clients may be authorized to receive two (2) units of service per week. These clients will receive two 7-packs of frozen meals or one 7-pack of frozen meals and one 7-pack of breakfast meals.

(d) In addition to the frozen meals, the service may include the provision of two (2) or more shelf-stable meals (not to exceed six (6) meals per six-month period) to meet emergency nutritional needs when authorized in the recipient's care plan.

(e) One frozen meal will be provided on days a client attends the Adult Day Health Centers. Meals provided, as part of this service, shall not constitute a "full nutritional regimen (three meals per day)".

(f) All menus must be reviewed and approved by the Meals Services Coordinator, a Registered Dietitian with licensure to practice in the State of Alabama and employed by the Operating Agency.

(g) The meals must be prepared and/or packaged, handling, transported, served, and delivered according all applicable health, fire, safety, and sanitation regulations.

(h) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care will be recouped.

(i) During times of the year when the State is at an increased risk of disaster from hurricanes, tornadoes, or ice/snow conditions, the meals vendor will be required to maintain, at a minimum, a sufficient inventory to operate all frozen meals delivery routes for two days. In the event of an expected storm or disaster, the Meals Coordinator will authorize implementation of a Medicaid approved Disaster Meal Services Plan.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit

Statutory Authority: 42 CFR Section 440.180 and the Home and Community-Based Waiver for the Elderly and Disabled.

History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:**

Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Amended: Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed July 21, 2008; effective October 16, 2008.

Rule No. 560-X-36-.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 C.F.R. Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled. Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-36-.06. Application Process.

(1) The case manager will receive referrals from hospital, nursing homes, physicians, the community and others for persons who may be eligible for home- and community-based services.

(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 redetermination assessment must be completed annually to determine eligibility.

(3) The case manager, in conjunction with the applicant's physician and the client and/or caregiver will develop a plan of care. All services will be furnished pursuant to a written plan of care. Payment will not be made for waiver services furnished prior to the development of the plan of care. The plan of care will include objectives, services, provider of services, and frequency of services. Changes to the

original plan of care are to be made as needed to adequately care for an individual. Revisions to the plan of care and the reasons for changes must be documented in the client's case record. Services provided 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 the Operating agency.

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

(a) The long term care admission notification 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) The Alabama Department of Public Health (ADPH) and the Alabama Department of Senior Services (ADSS) are 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 Elderly and Disabled Waiver.

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

(8) The ADPH and ADSS 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) ADPH and ADSS 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 retrospective review on a monthly basis of a random sample of individuals served under the Elderly and Disabled 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 ADPH and ADSS for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for Elderly and Disabled Waiver services or Medicaid eligibility but for the certification of waiver eligibility by ADPH or ADSS.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit

Statutory Authority: 42 CFR Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled.

History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed May 20, 2003; effective August 21, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed July 21, 2008; effective October 16, 2008.

Rule No. 560-X-36-.07. Financial Accountability of Operating Agencies.

(1) The financial accountability of providers for funds expended on home- and community-based services must be maintained and provide a clearly defined audit trail. Providers 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 provider will pay the travel cost of the auditors.

(2) The state agencies, as specified in the approved waiver document as operating agencies of home- and community-based services, will have their records audited at least 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 the recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

(4) The state agencies as specified in the approved waiver document will provide documentation of actual costs of services and administration. Such documentation will be entitled "Quarterly Cost Report for the Elderly and Disabled 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 October - December Due before March 1
- (b) 2nd January - March Due before June 1
- (c) 3rd April - June Due before September 1
- (d) 4th June - September Due before December 1

Failure to submit the actual cost documentation can 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 of 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 CFR, 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 act 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 the specific services are allowable expenses. Thus, contracts for case management, personal care, homemaker, respite care, adult day health, and home delivered meals 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 CFR 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 CFR 95.707. For automated data processing equipment, see 45 CFR 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 nongovernmental 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. Cost covered by other programs, such as:

(i) Prescription drugs,

(ii) Dental expense,

(iii) Physical therapy,

(iv) Ambulance service,

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

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 hearing,

(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 CFR 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 mail distribution clerk that distributes to all programs. 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 requirements of 45 CFR 95.507; these contracts must indicate:

1. "The specific services being purchased."
2. "The basis upon which the billing will be made - - (e.g., 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 fiscal year.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit

Statutory Authority: 42 CFR Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled.

History: Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed July 21, 2008; effective October 16, 2008.

Rule No. 560-X-36-.08. Fair Hearings.

(1) An individual or his/her legal representative who has received a notice of adverse action based on financial eligibility may request a fair hearing in writing within 60 days from the effective date of the action through the appropriate certifying agency.

(2) An individual or his/her legal representative who has received a notice of adverse action based on medical criteria may request a fair hearing in writing within 60 days from the effective date of the action through the Alabama Medicaid Agency Long Term Care Division.

(3) If the written request for a fair hearing is received within 10 days following the effective date of the adverse action, benefits can be continued pending the outcome of the hearing, if requested in writing.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit

Statutory Authority: 42 CFR Section 431, Subpart E.

History: Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987 and May 15, 1990. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-36-.09. Payment Methodology for Covered Services.

(1) Medicaid pays providers the actual cost to provide the service. Each covered service is identified on a claim by a HCPC code. Respite care will have one code for skilled and another for unskilled. Home delivered meals will also have one code and two modifiers. Frozen meals and shelf stable meals will be billed with a modifier. Breakfast meals will be billed without a modifier.

(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 claims can cover services performed in different months. If the submitted claim covers days 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 HCPC code.

(3) The basis for the cost will usually be based on audited past performance with consideration being given to the health care index and renegotiated contracts. The interim cost may also 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) The operating agencies as specified in the approved waiver document are governmental agencies; therefore, within one hundred and twenty days from the end of a waiver year, the interim cost for services must be adjusted to cost and the claims for the services provided during that year reprocessed to adjust payments to the actual cost incurred by each operating agency. Thus the cost for each service for each operating agency may differ. Since the actual cost incurred by each operating agency sets a ceiling on the amount it can receive, no claims with dates of service within that year will be processed after the adjustment is made.

(5) Accounting for actual cost and units of services provided during a waiver year must be accomplished on CMS 372 Report. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim cost:

(a) A waiver year consists of the twelve 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 by operating agencies are reported and paid by dates of service. Thus, all services provided during the twelve 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 in twelve 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: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit

Statutory Authority: 42 CFR Section 440.180 and the Home and Community-Based Waiver for the Elderly and Disabled, 45 CFR, Subpart 95, and OMB Circular A-87.

History: Emergency Rule effective December 4, 1987. Rule effective March 12, 1988. Amended May 15, 1990 and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed August 20, 2004; effective November 16, 2004. **Amended:** Filed March 21, 2005; effective June 17, 2005. **Amended:** Filed July 21, 2008; effective October 16, 2008.

Rule No. 560-X-36-10. 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 the written consent of the recipient, his or her attorney, and/or guardian, or upon subpoena from a court of appropriate jurisdiction.

Author: Ginger Wettingfeld, 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.

Rule No. 560-X-36-11. Appeal Procedure for Fiscal Audit.

(1) Fiscal audits of the Elderly and Disabled 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 Provider Audit Division and a letter is prepared making the appropriate findings official. If the operating agency deems that the findings are not justified, it may request an informal conference with the Director of the Provider Audit Division.

(2) The request for an informal conference must be in writing and received by Medicaid within 30 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 the attention of:

Director
Provider Audit Division.

(3) The decisions of the 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, it may request a fair hearing. The request must be in writing and received by Medicaid within 15 days from the date of the informal conference decision letter.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit

Statutory Authority: 42 CFR Section 431, Subpart E.

History: New Rule: Filed July 21, 2008; effective October 16, 2008.

Rule No. 560-X-36-.12. Third Party Liability.

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 ensure that Medicaid is the payor of the last resort. 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.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit.

Statutory Authority: 42 CFR Section 433, Subpart D; Section 1902(a)(25), Social Security Act; Code of Alabama, 1975 Sections 22-6-6.

History: New Rule: Filed July 21, 2008; effective October 16, 2008.