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State/Territory Name: Alaska

State Plan Amendment (SPA) #: 15-0004

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Financial Management Group

DEC 17 2015

Jon Sherwood, Deputy Commissioner
Department of Health and Social Services
Post Office Box 110601
Juneau, AK 99811-0601

RE: AK State Plan Amendment (SPA) Transmittal Number #15-0004 – Approval


Dear Mr. Sherwood:

We have reviewed the proposed amendment to Attachments 4.19-A, B and D of your Medicaid State plan submitted under transmittal number (TN) 15-0004. This SPA freezes rates for SFY 2016 for inpatient hospital, long-term care facility, nursing facility, federally-qualified health care centers, and the infant learning targeted case management at SFY 2015 levels.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 15-0004 is approved effective as of July 1, 2015. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan page.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' RO NIRT Representative at 208-861-9838 or Thomas.Couch@cms.hhs.gov.

Sincerely,


Kristin Fan
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 15 - 004	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, 2015	

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 447.201, 42, CFR 447.302	7. FEDERAL BUDGET IMPACT: a. FFY <u>2015</u> \$ <u>0</u> b. FFY <u>2016</u> \$ <u>(8,000,000) P&I</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B pages 1, 1.1, 2a, 2b, 4, 6, 7 and 11a. 4.19D page 7 4.19A page 7	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B pages 1, 1.1, 2a, 2b, 4, 6, 7 and 11a. 4.19D page 7 4.19A page 7

10. SUBJECT OF AMENDMENT:
Updating rates

11. GOVERNOR'S REVIEW (Check One):

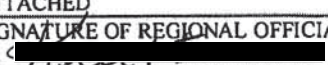
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Does not wish to comment
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Department of Health and Social Services P.O. Box 110660 Juneau, Alaska 99811-0660
13. TYPED NAME: Jon Sherwood	
14. TITLE: Deputy Director SOA DHSS	
15. DATE SUBMITTED: 9/21/2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: DEC 17 2015
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2015	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG
23. REMARKS: 11/30/15 - State authorized P& I change to Box 7.	

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 years have elapsed. The agreement may be renewed after it expires if the facility still qualifies for reimbursement under this Subsection. A re-basing of the prospective payment rate for the renewed agreement will occur in accordance with Subsection IVa.

A facility electing reimbursement under the optional methodology described in this Subsection for fiscal years beginning in calendar year 2003 will be re-based and have its prospective payment rate based in the rate calculated under Subsection IVa. Fiscal year 2000 is used as the base year for facilities with fiscal years ending on December 31 and fiscal year 2001 is used as the base year for all others.

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 and 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 year 2016, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

Methods and Standards forEstablishing Payment Rates: Other Types of CareAdvanced Nurse Practitioners

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule. State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fees schedule rates are the same for both governmental and private providers. The fee schedule and its effective date are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

The fee schedule was last updated, to be effective for services on or after 7/1/2015.

Ambulatory Surgical Clinic Services

Payment is made to ambulatory (outpatient) surgical clinics on a prospectively determined rate. Payment covers all operative functions attendant to medically necessary surgery performed at the clinic by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the beneficiary while in the clinic. The payment excludes the physician, radiologist, and anesthesiologist fee. State developed fee schedule rates are the same for both public and private providers and the fee schedule is published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

The fee schedule was last updated, to be effective for services on or after 7/1/2015.

Behavior Rehabilitation Services

Payment for Behavior Rehabilitation Services is a fee-for-service basis, with one day being the unit of service. Rates are based upon a periodic rate study using a prospective staffing based rate model that uses data gathered by the State Department of Labor reporting the prevailing wages in the State of Alaska. Specific position classifications were selected to reflect the comparable staffing requirements needed to provide quality rehabilitative services to the identified population. A factor is used to compensate for employee benefits and facility operating costs and supplies. Board and room are not included in the Behavioral Rehabilitative Service rate paid to the provider. These rates are periodically adjusted based on appropriate cost-of-living adjustments and other market indicators and program standards. Rates and rate methodology are found in Residential Behavioral Health Service handbook 2013 at <http://dhss.alaska.gov/dbh/Documents/TreatmentRecovery/RBRS%20Documents/BR%20Handbook%2010-28-13.pdf>

Certified Nurse Anesthetist Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factor and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

Chiropractic Services

Payment for manual manipulation to correct subluxation of the spine and x-rays is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers. The fee schedule and its effective dates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

The fee schedule was last updated, to be effective for services on or after 7/1/2015.

Methods and Standards forEstablishing Payment Rates: Other Types of Care

Community Health Aides Payment for the services of community health aides III and IV or a community health practitioner certified by the state is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology, the provider's lowest charge, or the state maximum allowable for the procedures that do not have an RVU. For EPSDT screening services paid at 100 percent of the Resource Based Relative Value Scale methodology used for physicians. Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factor and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

Dental Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

The fee schedule was last updated, to be effective for services on or after 7/1/2015.

Direct Entry Midwife Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

The fee schedule was last updated to be effective for services on or after 7/1/2015.

EPSDT Screening Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology for physicians or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers, Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

The fee schedule was last updated to be effective for services on or after 7/1/2015.

Midwife Birthing Center Services

Rates for midwife services provided in a birthing center are based on the lesser of billed charges, 85% of the Medicare Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge, plus an amount equal to 50% of the statewide average rate for a normal vaginal hospital birth for the previous state fiscal year. See fee schedule rates for Advance Nurse Practitioners (p.1 of this attachment) and Direct Entry Midwives (page 1.1 of this attachment) for fee schedule rates.

Federally Qualified Health Center Services

Payment for Federally Qualified Health Center Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

Prospective Payment System

All Federally Qualified Health Centers (FQHCs) are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease on the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each center fiscal year thereafter, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the center. The center must supply documentation to justify scope of service adjustments. For state fiscal year 2016, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase in the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

For newly qualified FQHCs after State fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers, and adjustments for increases or decreases on the scope of service furnished by the Center during that fiscal year. For state fiscal year 2016, after the initial year for a center, the center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase on the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

Alternative Prospective Payment System

Beginning with the Federally Qualified Health Center's fiscal year 2003 (FY03), qualifying centers may agree to have their payment rates set using an alternative prospective payment methodology outlined below. The alternative payment methodology agreement between the State and the Federally Qualified Health Center results in payment to the FQHC of an amount at least equal to the Prospective Payment System payment rate. The State annually evaluates the Medicare Economic Index for primary care services to insure the alternative rate is at least equal to or greater than the PPS rate.

Base rates are calculated prospectively on a per visit basis equal to 100 percent of the inflated average, as explained below, of the allowable and reasonable costs of services furnished during the center's fiscal years 1999 and 2000. The base year costs for FY99 are inflated using the number set out in the first quarter 1999 publication of Global Insight's *Health Care Cost Review*, Skilled Nursing Facility Total Market Basket, inflated to 2002.

The center's allowable and reasonable costs for fiscal year 2000 are inflated by the number set out in the first quarter 2000 publication of Global Insight's *Health Care Cost Review*, Skilled Nursing Facility Total Market Basket, inflated to 2002. The cost per visit is then adjusted for any increase or decrease in the scope of services, based on documentation supplied by the center to justify such an adjustment. For each subsequent fiscal year, the payment rate is increased using the first quarter publication of Global Insight's *Health Care Cost Review*, Skilled Nursing Facility Total Market Basket, then adjusted for any increase or decrease in the scope of services. At least every four years, the department will change the base year to reflect more current cost data for establishing rates. For the state fiscal year 2016, if the center's base year is not changing, then the center's payment rate is not increased using the first quarter publication of Global Insight's *Health Care Cost Review*, Skilled Nursing Facility Total Market Basket, but is adjusted for any increase or decrease in the scope of services.

Prescription drugs and hospital deliveries are excluded from this payment system because they are subject to different methodologies per state regulation.

If the rate established using the alternative prospective payment methodology does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the center may apply to the deputy commissioner for consideration of exceptional relief from the rate-setting methodology. The application must include the estimated amount necessary to allow reasonable access to quality care, reasons for the relief requested, management actions taken to respond to the situation, corresponding audited financial statements, descriptions of efforts to offset the deficiencies, an analysis of community needs for the services and how Medicaid patients will lose access available to the general public in the same geographic location without this relief, and any other information requested by the deputy commissioner to evaluate the request.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

The alternative payment methodology agreement between the State and the federally Qualified Health Center will result in payment to the FQHC of an amount that is equal to the Prospective Payment System payment rate. The State will annually evaluate the alternative payment rate to ensure that the alternative rate is at least equal to or greater than the PPS rate and that it does not exceed the payment limit set under 42 CFR 447.300 through 447.371.

Initial payments for FQHCs becoming qualified after State FY00 are established by computing a state-wide weighted average payment to other centers or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted. For each subsequent year, the center will be paid the rate it was entitled to the previous clinic fiscal year plus the percentage increase in the Skilled Nursing Facility Total Market Basket and adjusted for increases or decreases in the scope of service furnished by the Center during that center's fiscal year. For state fiscal year 2016, if it is a center's subsequent year, the center will be paid the rate it was entitled to the previous fiscal year with no percentage increase in the Skilled Nursing Facility Total market Basket, but adjusted for increases or decreases in the scope of services furnished by the center during that center's fiscal year.

Methods and Standards for EstablishingPayment Rates: Other Types of CareMental Health Clinic Services

Mental health clinic services provided by a community mental health clinic, state operated mental health clinic, or mental health physician clinic (which is a group of psychiatrists or other mental health professionals working under the supervision of a psychiatrist) are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Community mental health clinics bill the Division of Behavioral Health under a separate reimbursement schedule for performing pre-admission screening and annual resident reviews (PASARR) of mentally ill persons seeking admission to or residing in long-term care facilities. The State assures that the requirements of 42 CFR 447.321 regarding upper limits of payment will be met. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of mental health clinic services. The agency's fee schedule was updated 12/26/2008 and is published in the Departments' Community Behavioral Health Clinic billing manual dated 6/29/12 available at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Mental Health Rehabilitation Services

Mental health rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Except as otherwise noted in the plan state developed fee schedule rates are the same for both governmental and private providers of mental health rehabilitation services. The agency's fee schedule was updated 12/26/08 and is published in the Department's Community Behavioral Health Clinic billing manual dated 6/29/2012 available at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Nurse-Midwife Services

Payment is made at the lesser of billed charges, 85% of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of the amount billed the general public or at the Medicare fee schedule. Drugs are covered at 95 percent of the AWP but without a dispensing fee. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of nurse-midwife services. The fee schedule was last updated, to be effective for services on or after 7/1/2015 and is available at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Methods and Standards for Establishing Payment Rates: Other Types of CarePhysician Services:

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established Relative Value Unit (RVU). The Resource Based Relative Value Scale methodology is that described in 42 CFR 414 except that increases and reductions to the average payment made for an individual procedure billed at least ten times during the previous fiscal year will be phased in until the year 2000. The relative value units used are the most current version published in the Federal register. Non-routine office supplies are reimbursed at the lesser of billed charges or the state maximum allowable.

Surgical reimbursement is in accordance with the Resource Based Value Scale methodology except that multiple surgeries performed on the same day are reimbursed at 100 percent for each additional surgery; bilateral surgeries are reimbursed at 150 percent of the RBRVS rate; co-surgeons are reimbursed by increasing the RBRVS rate by 25 percent and splitting the payment between the two surgeons; and supplies associated with surgical procedures performed in a physician's office are reimbursed at the lesser of billed charges or the state maximum allowable. Payment is made to surgical assistants at the lesser of billed charges or 25 percent of the Resource Based Relative Value Scale methodology.

Payment to physicians for in-office laboratory services are reimbursed at the lesser of the amount billed the general public or the Medicare fee schedule.

Payment is made to independently enrolled hospital-based physician for certain services at the lesser of the amount billed the general public or 100 percent of the Resource Based Relative Value Scale methodology.

Anesthesia services are reimbursed using the base units and time units and a state determined conversion factor.

State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule was last updated, to be effective for services on or after 7/1/2015 and is available at:

<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Podiatry Services

Payment is at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule was last updated, to be effective for services on or after 7/1/2015, and is available at:

<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Prescribed Drugs

- (a) Reimbursement will be made to the provider for reasonable and necessary postage or freight costs incurred in the delivery of the prescription from the dispensing pharmacy to a recipient in a rural area. Cross-town postage or delivery charges are not covered. Handling charges are included in the dispensing fee (below) and not directly reimbursed.
- (b) The payment for drugs for which the Centers for Medicare and Medicaid has established a specific upper limit amount will be the lowest of the amount billed, estimated acquisition cost, state maximum allowable cost or the federal upper limit plus the dispensing fee.
- (c) The payment for drugs for a covered entity described in U.S.C. 256b that indicates it will use covered outpatient drugs purchased through the 340B drug pricing program to bill to Medicaid will be the lower of the submitted actual acquisition cost, the state maximum allowable cost, the federal upper limit, or the estimated acquisition cost plus the dispensing fee.
- (d) The payment for drugs for a facility purchasing drugs through the Federal Supply Schedule or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program, will be the lower of the billed amount, the wholesale acquisition cost minus 15 percent, the state maximum allowable cost, or the federal upper limit plus the dispensing fee.
- (e) The payment for drugs other than those of (b) through (d) above, and for brand names of multiple source drugs specified by the prescriber in accordance with 42 C.F.R. 447.512 will be the assigned dispensing fee plus the estimated acquisition

TN NO: 15-004 Approval Date: DEC 17 2015 Effective Date: 7/1/15
Supersedes: TN No: 14-006

Targeted Case Management

For care coordination services see Substance Abuse Rehabilitation Services.

For family and client support services see Mental Health Rehabilitation Services.

Payment Methodology for all types of Targeted Case Management

Payment for Infant Learning Program Targeted Case management will be based on a monthly encounter rate. The payment rate is calculated prospectively and is based on the following:

Rate Computation Methodology

The prospective rate for payment of case management services is computed annually using the following formula. The data for this computation will be taken from the base year, that is the first full year before providers billed for Targeted Case Management services under this section, and will be inflated forward using an inflation index approved by the Department. For fiscal year 2016, the data for this computation taken from the base year will not be inflated forward.

<u>Compute the</u>	Annual Case Manager salary and fringe benefits
<u>Plus</u>	Other anticipated operating cost including travel, supplies, telephone, and occupancy cost
<u>Plus</u>	Direct supervisory cost
<u>Plus</u>	Average indirect administrative cost of provider organization
<u>Divided by</u>	TOTAL STATEWIDE NUMBER OF CASE MANAGERS
<u>Equals</u>	TOTAL STATEWIDE ANNUAL COST PER CASE MANAGER
<u>Divided by</u>	12
<u>Equals</u>	MONTHLY STATEWIDE AVERAGE COST PER CASE MANAGER
<u>Divided by</u>	Statewide average number of children served per month
<u>Equals</u>	TOTAL STATEWIDE AVERAGE MONTHLY COST PER CHILD

The total cost per case manager is the sum of the case manager's reasonable salary, direct supervisory cost, indirect administrative costs of the provider organization, and other operating costs such as travel, supplies, occupancy, and telephone. Dividing the state wide average cost per case manager by twelve (12) months yields the average statewide monthly cost per manager. Dividing the statewide monthly cost per case manager by the average monthly number of children served statewide results in the total monthly cost per child. This is the encounter rate to be used by the provider for billing whenever a Medicaid eligible client receives a TCM service during the month. Providers may only bill the encounter rate once per child per month and must keep documentation to verify this practice.

Payment Methodology for Under 21 Targeted Case Management

Rate Determination: The monthly rate for case management services is based on the total average monthly cost per client served by the provider. The monthly rate is limited to the provider's direct service and administrative costs associated with case management service delivery. The rate is computed by taking the provider's monthly case management cost divided by the monthly number of clients that are provided case management services.

The rate is established prospectively. In the first year, the rate is based on estimates of cost and the number of clients to be served. For subsequent years, the rate is based on actual case management costs for previous years. A cost statement is completed at the end of each state fiscal year once the actual costs incurred have been determined.

Payment Methodology: Payment will be made through MMIS. The provider will bill at the full monthly rate for each client provided case management services during that month. An encounter is a case management activity performed on the client's behalf. Each encounter will be documented to support the billing. Encounters include but are not limited to in-person, phone, mail, email and other means.

(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 year 2016, 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 of 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: