

TABLE OF CONTENTS

CHAPTER FIFTY SIX

FEDERALLY QUALIFIED HEALTH CENTER REIMBURSEMENT

<u>Rule</u>	<u>Title</u>	<u>Page</u>
560-X-56-.01	Preface	1
560-X-56-.02	Introduction	1
560-X-56-.03	Definitions	3
560-X-56-.04	Reimbursement Methodology	6
560-X-56-.05	Reserved	7
560-X-56-.06	Encounters	8
560-X-56-.07	Overhead Costs	8
560-X-56-.08	Personnel Costs	12
560-X-56-.09	Travel Expense	13
560-X-56-.10	Property Costs	15
560-X-56-.11	Costs to Related Parties	22
560-X-56-.12	Chain Operations	22
560-X-56-.13	Unallowable Expenses	23
560-X-56-.14	Accounting Records	27
560-X-56-.15	Cost Reports	29
560-X-56-.16	Audit Adjustment Procedures	31
560-X-56-.17	Appeals	32
560-X-56-.18	Negligence and Fraud Penalties	32
560-X-56-.19	Cost Report Preparers	33

Chapter 56. Federally Qualified Health Center Reimbursement

Rule No. 560-X-56-.01. Federally Qualified Health Center Reimbursement- Preface. This Chapter states the Medicaid policy regarding Federally Qualified Health Centers, hereinafter referred to as FQHCs, reimbursement and establishes the accepted procedures whereby reimbursement is made to FQHC providers. Because of the length and complexity of this Chapter, it has been divided into sections to facilitate its utilization.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2406 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October, 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.02. Introduction

(1) This Chapter of the Alabama Medicaid Administrative Code has been published by the Alabama Medicaid Agency (Medicaid) to accommodate program needs and the administrative needs of FQHCs and to help ensure that the reasonable cost regulations are uniformly applied state wide without regard to where covered services are furnished.

(2) The Alabama Medicaid Program is administered by Medicaid under the direction of the Governor's Office. Reimbursement principles for FQHCs are outlined in the following sections of this Chapter. These principles, hereinafter referred to as "Medicaid Reimbursement Principles," are a combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and principles and procedures published by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated FQHCs. These principles are not intended to be all inclusive, and additions, deletions, and changes to them will be made by Medicaid as required. Providers are urged to familiarize themselves fully with the following information, as cost reports must be submitted to Medicaid in compliance with this Chapter and other provisions of the Medicaid Administrative Code.

(3) If the Medicaid Administrative Code is silent on a given point, Medicaid will normally rely on appropriate OMB circulars (i.e., OMB A87, OMB 122, OMB 128, OMB 133), Medicare (Title XVIII) Principles of Retrospective Reimbursement and, in the event such Medicare Principles provide no guidance, Medicaid may impose other reasonability tests. The tests include, but are not limited to, such tests as:

- (a) Does the cost as reported comply with generally accepted accounting principles?
- (b) Is the cost reasonable on its own merit?
- (c) How does the cost compare with that submitted by similarly sized centers furnishing like covered services?

(d) Is the cost related to covered services and necessary to the operation of a center?

(4) It is recognized that there are many factors involved in operating an FQHC. Costs may vary from one facility to another because of scope of services, level of care, geographical location, and utilization. Considerable effort has been made to recognize such variables during the development of this Chapter. Only reported costs reflecting such variables without exceeding the "prudent buyer" concept or other applied tests of reasonability will be allowed by Medicaid. Implicit in the intention that actual costs be paid to the extent they are reasonable, is the expectation that the center seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer would pay for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

(5) Records must be kept by the provider which document and justify costs, and only those costs which can be fully and properly substantiated will be allowed by Medicaid.

(6) Unallowable costs which are identified during either desk audits or field audits will be disallowed despite similar costs having been included in prior cost reports without having been disallowed.

(7) The only source of the funds expended by Medicaid is public funds, exacted from the taxpayers through state and federal taxes. Improper encroachment on these funds is an affront to the taxpayers and will be treated accordingly.

(8) To assure only necessary expenditures of public money, it will be the policy of Medicaid to:

(a) Conduct on-site audits of facilities on an unannounced basis, although prior announcement may be made at the discretion of Medicaid.

(b) Determine audit exceptions in accordance with Medicaid Reimbursement Principles.

(c) Allow only non-extravagant, reasonable, necessary and other allowable costs and demand prompt repayment of any unallowable amounts to Medicaid.

(9) In the event desk audits or field audits by Medicaid's staff reveal that providers persist in including unallowable costs in their cost reports, Medicaid may refer its findings to the Medicaid Program Integrity Division, Medicaid Legal Counsel, and/or the Alabama Attorney General.

(10) While the responsibility for establishing policies throughout the Medicaid Program rests with Medicaid, comments on the contents of this Chapter are invited and will be given full consideration.

Author: Sandra Johnson, Associate Director, Provider Audit, Q/A Reimbursement

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994. **Amended:** Filed September 22, 2008; effective December 17, 2008.

Rule No. 560-X-56-.03. Definitions

(1) **Accrual Method of Accounting** - Revenues must be allocated to the accounting period in which they are earned and expenses must be charged to the period in which they are incurred. This must be done regardless of when cash is received or disbursed.

(2) **Chapter** - This Chapter (Chapter Fifty-Six) of the Alabama Medicaid Agency Administrative Code.

(3) **Costs Not Related to Patient Care** - Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs.

(4) **Costs Related to Patient Care** - These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.

(5) **Covered Costs** - Allowable direct and indirect costs that are reasonable and necessary in rendering covered health care services. To be recognized, costs (as indicated in the State Plan) must be identified in auditable accounting records and allocated on a reasonable basis between the delivery of covered type services and all other center activities.

(6) **Depreciation** - That amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period of operation.

(7) **Encounters** - Encounters are face-to-face contacts between a patient and a health professional for the provision of medically necessary services.

(a) **Ancillary Encounter** - Face-to-face contact between a patient and a health professional for lab or x-ray services only.

(b) **Dental Encounter** - Face-to-face contact between a patient and a health professional for the provision of dental services.

(c) **Medical Encounter** - Face-to-face contact between a patient and a health professional for the provision of medical services (i.e., physician, physician assistant, nurse practitioner).

(d) **EPSDT, Family Planning, or Prenatal Encounter** - Face-to-face contact to receive services within the parameters of the program guidelines.

(8) Fair Market Value - The bona fide price at which an asset would change hands or at which services would be purchased between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having a reasonable knowledge of the relevant facts.

(9) Federally Qualified Health Center - Facilities or programs which meet one of the following requirements:

(a) receives a grant under Section 329, 330, or 340 of the Public Health Act;

(b) meets the requirements for receiving such a grant as determined by the Secretary based on recommendations of the Health Resources and Services Administration within the Public Health Service; or

(c) qualifies through waivers of the requirements described above as determined by the Secretary for good cause.

(d) outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).

(10) Fiscal Year - The 12 month period upon which providers are required to report their costs, also called the reporting period.

(11) Fringe Benefits - Fringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death.

(12) Full Time Equivalent (FTE) - The result of a calculation which determines the average number of employees per position working the customary work week full time.

(13) CMS - The Centers for Medicare & Medicaid Services, an agency of the U. S. Department of Health and Human Services.

(14) HIM-15 - The title of the Medicare Provider Reimbursement Manual, a publication of CMS.

(15) Home Office Costs - See Rule 560-X-56-.12 for the in-depth discussion and treatment of home office costs.

(16) Interest - Cost incurred for the use of borrowed funds.

(a) Necessary Interest - Incurred to satisfy a financial need of the provider on a loan made for a purpose directly related to patient care. Necessary interest cannot include loans resulting in excess funds or investments.

(b) Proper Interest - Must be necessary as described above, incurred at a rate not in excess of what a prudent borrower would have to pay in the money market at the time the loan was made, and incurred in connection with a loan directly related to patient care or safety.

(17) Interim Encounter Rate - A rate intended to approximate the provider's actual or allowable costs of services furnished until such time as actual allowable costs are determined.

(18) Medicaid - The Alabama Medicaid Agency.

(19) Medicaid Reimbursement Principles - A combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and procedures and principles published by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated FQHCs.

(20) Medicare Economic Index (MEI) - A measure of inflation faced by physicians with respect to their practice costs and general wage levels. The MEI is used to inflate the FQHC's prospective payment system (PPS) rate from the previous year.

(21) Necessary Function - A function being performed by an employee which, if that employee were not performing it, another would have to be employed to do so, and which is directly related to providing FQHC services.

(22) Pension Plans - A pension plan is a type of deferred compensation plan which is established and maintained by the employee primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement.

(23) Proprietary Provider - Provider, whether a sole proprietorship, partnership, or corporation, organized and operated with the expectation of earning profit for the owners as distinguished from providers organized and operated on a nonprofit basis.

(24) Provider - A person, organization, or facility who or which furnishes services to patients eligible for Medicaid benefits.

(25) Prudent Buyer Concept - The principle of purchasing supplies and services at a cost which is as low as possible without sacrificing quality of goods or services received.

(26) Reasonable Compensation - Compensation of officers and/or employees performing a necessary function in a facility in an amount which would ordinarily be paid for comparable services by a comparable facility.

(27) Reasonable Costs - Necessary and ordinary cost related to patient care which a prudent and cost-conscious businessman would pay for a given item or service.

(28) Related - The issue of whether the provider and another party are "related" will be determined under the HIM-15 rules as to classification as "related" parties. (See HIM-15.)

(29) Secretary - "Secretary" means the Secretary of Health and Human Services or his delegate.

(30) Sick Leave - A benefit granted by an employer to an employee to be absent from their job for a stipulated period of time without loss of pay.

(31) State Plan - The State Plan published by the State of Alabama under Title XIX of the Social Security Act Medical Assistance Program.

(32) Unallowable Costs - All costs incurred by a provider which are not allowable under the Medicaid Reimbursement Principles.

(33) Vacation Costs - A vacation benefit is a right granted by an employer to an employee (a) to be absent from his job for a stipulated period of time without loss of pay or (b) to be paid an additional salary in lieu of taking the vacation.

Author: Sandra Johnson. Associate Director, Provider Audit, Q/A Reimbursement
Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

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Rule No. 560-X-56-.04. Reimbursement Methodology

(1) A Medicaid prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs) was enacted into law under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. As described in section 1902(aa) of the Social Security Act, FQHCs will be paid under a prospective payment system effective January 1, 2001. Prior to enactment of BIPA, FQHCs were reimbursed by an established encounter rate based on 100% of reasonable allowable cost for Medicaid covered services provided by the FQHC. With the implementation of BIPA, FQHC providers that provided Medicaid covered services for the period October 1, 2000, through December 31, 2000, will file a cost report and it will be settled. For the period January 1, 2001, through September 30, 2001, Alabama Medicaid Agency will pay FQHCs 100% of the average of their reasonable costs of providing Medicaid covered services during FY 1999 and FY 2000, adjusted to take into account any increase (or decrease), see paragraph (3) below, in the scope of services furnished during FY 2001 by the FQHC (calculating the payment amount on a per visit basis). Beginning in FY 2002, and for each fiscal year thereafter, each FQHC is entitled to the payment amount (on a per visit basis) to which the FQHC was entitled to in the previous 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 FQHC during that fiscal year.

(2) Reimbursement for an enrolled out-of-state FQHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state FQHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

(3) A new FQHC provider or a provider who constructs, leases, or purchases a facility, or has a Medicaid approved change in the scope of services, can request reimbursement based on an operating budget, subject to the ceiling established under this rule. After the actual cost report is received and desk reviewed for the budget period, an actual encounter rate will be determined. In this event, the FQHC may be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. This difference may be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference. After the initial year, payment shall be set using the MEI methods used for other FQHCs. An FQHC that has a change of ownership can retain the previous owner's encounter rate if desired.

(4) **Costs Reimbursed by Other Than FQHC Encounter Rate.** Costs that are reimbursed by other Alabama Medicaid Agency programs will not also be reimbursed in the FQHC Program. Examples of such reimbursements include, but are not limited to:

(a) Maternity Waiver - Primary Contractor

(Note: Costs for Maternity Waiver sub-contractors are not an allowable cost and will be shown only in the non-reimbursable section of the cost report.)

(b) Prescription Drugs by enrolled pharmacy providers

(c) In-patient and out-patient surgical service fee-for-service payments.

In order to keep from paying for such services twice, the payments for the programs above will be deducted from the FQHC settlements.

(5) Unrestricted grants, gifts, private donations or the income from such items, and income from endowments will not be deducted from operating costs in computing reimbursable cost. Public Health Service Grants are considered unrestricted grants. Grants, gifts, private donations, or the income from such items, or endowment income designated by a donor for paying specific operating costs must be deducted from the particular operating cost or group of costs.

Author: Keith Boswell, Reimbursement/QA

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act Sec. 1902(a)(13), Balanced Budget Act of 1997, Sec. 4712(c), 42 CFR Section 405.2460 - .2472, and 447.371, Section 702, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

History: Rule effective April 15, 1993. Amended October 1, 1993; March 15, 1994; July 10, 1998, January 13, 2000. **Amended:** Emergency Rule filed and effective March 20, 2001. **Amended:** Filed March 20, 2001; effective June 15, 2001. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-56-.05. RESERVED

Rule No. 560-X-56-.06. Encounters

Encounters are face-to-face contacts between a patient and a health professional for the provision of medically necessary services. Contacts with more than one health professional and multiple contacts with the same health professional, that take place on the same day and at a single location, constitute a single encounter unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. This does not apply to dental service; however, dental services are limited to one dental encounter per date of service. Therefore, a patient can have one dental encounter and one other encounter on the same day. Services incident-to an encounter are inclusive.

Encounters are classified as either billable or non-billable. Billable encounters are visits for face-to-face contact between a patient and a health professional in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable encounters are forwarded to the Fiscal Agent for payment through the proper filing of claims forms. Non-billable encounters are visits for face-to-face contact between a patient and health professional for services other than those listed above (i.e., visits to social worker, LPN). Such services include, but are not limited to, administering injections only, blood pressure checked only, and TB skin testing. Non-billable encounters can not be forwarded to the Fiscal Agent for payment. The costs of the non-billable encounters will be included in the allowable costs; however, the non-billable encounter will not be counted as an encounter on the cost report.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.07. Overhead Costs

(1) Overhead costs are those costs not directly related to patient care. Overhead costs are those costs related to the FQHC's facility and administration and management of the FQHC.

- (2) Examples of Overhead Costs include, but are not limited to:
- (a) Salaries and benefit costs of the administration staff (Owners compensation should be limited to reasonable cost - i.e., that which would be paid to an unrelated employee performing the same function).
 - (b) Accounting and Auditing
 - 1. Routine Bookkeeping
 - 2. Preparation of cost reports
 - 3. Auditing and related statements
 - (c) Nominal meeting expenses for Board Members

- (d) Legal costs related to patient care
- (e) Data Processing
 - 1. Owned
 - 2. Rented
 - 3. Outside purchased service
- (f) Housekeeping
- (g) Maintenance
- (h) Security
- (i) Supplies
- (j) Malpractice Insurance
- (k) General Insurance
- (l) Telephone
- (m) Utilities (power, gas, and water)
- (n) Rent
- (o) Maintenance and Repairs
- (p) Depreciation
- (q) Amortization
- (r) Mortgage Interest
- (s) Other Interest
- (t) Medical Records
- (u) Home Office Cost (if appropriate)
- (v) Management fees not exceeding the cost of the provider of the services and not excluded under another section of this Chapter
- (w) Other costs, if appropriate

(3) Purchase Discounts and Allowances, and Refunds of Expenses. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense. Discounts, in general, are reductions granted for the settlement of debts. Allowances are deductions granted for damage, delay, shortage, imperfection or other cause, excluding discounts and returns. Refunds are amounts paid back or a credit allowed on account of an over-collection. Rebates represent refunds of a part of the cost of goods or services. A rebate is commonly based on the total amount purchased from a supplier and differs from a quantity discount in that it is based on the value of purchases, whereas quantity discounts are generally based on the quantity purchased.

All discounts, allowances, and refunds of expenses are reductions in the cost of goods or service purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they were received.

Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due.

Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever

the classification of purchase discounts, like treatment in reducing allowable cost is required.

In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

As with discounts, allowances and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party organizations paying on the basis of cost.

(4) Advertising Costs. The allowability of advertising costs depends on whether they are reasonable, appropriate and helpful in developing, maintaining, and furnishing covered services to Medicaid beneficiaries. To be reimbursable, such costs must be common and accepted occurrences in the field of the center's activity.

Advertising costs incurred in connection with the center's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. These costs will be limited to \$100.00 per year for the main clinic and each satellite that operates as a full-time clinic (i.e., if a FQHC has a main clinic and four satellites, it will be limited to a total of \$500.00 per year). Costs connected with fund-raising are not included in this category and are therefore nonallowable.

Costs of advertising for the purpose of recruiting medical and paramedical personnel for the center's salaried staff are allowable. Costs incurred in advertising for administrative or clerical personnel are allowable if the personnel would be involved in patient care activities or the development and maintenance of the facility.

Advertising costs incurred in connection with obtaining bids for construction or renovation of the center's facilities should be included in the capitalized cost of the asset.

(5) Insurance Costs. The reasonable costs of insurance purchased from a commercial carrier and not from a limited purpose insurer are allowable if the type, extent, and cost of coverage are consistent with sound management practice. Where a center has purchased insurance without the customary deductible feature and, as a result, is charged a substantially higher premium, the amount of the insurance premium which exceeds the insurance premium with the customary deductible clause is not an allowable cost.

Generally, the following types of insurance are recognized:

(a) Property Damage and Destruction. This type of insurance covers losses due to the damage to, or destruction of, the facility's physical property. Coverage is available to insure against losses resulting from fire or lightning, windstorm, earthquake, sprinkler leakage, water damage, automobile damage, etc.

(b) Liability. This insurance includes professional liability (malpractice, error in rendering treatment, etc.), worker's compensation, automobile liability, and general liability.

(c) Consequential Loss or Indirect Loss. There are various indirect losses a center may incur in connection with property damage or other occurrences which interrupt the normal operation of the institution. The cost of business interruption or other similar insurance is allowable; however, the premium costs for "guaranteeing profits" is not allowable.

(d) Theft Insurance. This generally includes fidelity bonds and burglary insurance.

(6) Taxes. When a center is liable for the payment of certain taxes, such payments made in accordance with the levying enactment of the state and lower levels of government may be included in allowable costs. The program will pay its proportionate share of such allowable expenses.

Center's are expected to obtain exemption from taxation whenever they can legally do so. When such exemptions are available but the center neglects to take advantage of them, incurred expenses for such taxes will not be recognized as allowable costs under the program.

Tax expense should not include fines and penalties. In general, taxes which the center is required to pay are includable in allowable costs except for:

(a) Federal income and excess profit taxes.

(b) State or local income and excess profit taxes.

(c) Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

(d) Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives.

(e) Taxes on any property which is not used in the rendition of covered services.

Taxes which are allowable for inclusion in costs under the program generally are included in overhead costs of the center.

(7) Membership Costs. Centers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary operating costs. Generally, costs of centers memberships in professional, technical, and business related organizations are allowable for purposes of program reimbursement. Generally, social and fraternal organizations concern themselves with activities unrelated to their members' professional or business activities and are, therefore, not allowable.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.08. Personnel Costs

(1) Orientation and On-The-Job Training. The costs of orientation and on-the-job training are recognized as normal operating costs and are allowable. Ordinarily, such training would be imparted within the center setting. If, however, the training requires outside instructions, costs of such training are allowable, if reasonable.

(2) Fringe Benefits. Fringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death.

(3) The costs of fringe benefits must be reasonable and related to patient care. Medicaid recognizes the following fringe benefits:

(a) Facility contributions to certain deferred compensation plans, if the plan does not favor top management.

(b) Facility contributions to certain pension plans, if the plan does not favor top management.

(c) Paid vacation or leave, paid holidays, paid sick leave, voting leave, court or jury duty leave, all of which generally are included in employee earnings.

(d) Cost of health and life insurance premiums paid or incurred by the facility if the benefits of the policy inure to the employee or his beneficiary, if the plan does not favor top management.

Other items not enumerated above may represent fringe benefits.

However, before any other item is treated as a fringe benefit, refer it to the Medicaid Agency for approval.

(4) Sick Leave. The reasonable cost of sick leave taken by an employee of a center is recognized as a fringe benefit and included in allowable costs only when the facility makes payment for the sick leave. Payment in lieu of sick leave taken is not recognized by the program as payment for sick leave but is recognized as additional compensation. To be included in allowable costs, this payment in lieu of sick leave taken, along with other forms of compensation paid to an employee, must be reasonable.

(5) Vacation Costs. A vacation benefit is a right granted by an employer to an employee (a) to be absent from his job for a stipulated period of time without loss of pay or (b) to be paid an additional salary in lieu of taking the vacation. Vacation costs must meet all of the following conditions to be included in allowable costs.

(a) These costs must be included in the cost reporting period in which they are earned by the employee and must be computed from actual payroll records as related to each employee.

(b) Where the center's vacation policy is consistent among all employees, the vacation must be taken or, if the employee elects to be paid in lieu of taking a vacation, the payment must be made within the period consistent with the vacation policy established by the center. Where the policy is not consistent among all

employees, the vacation must be taken or payment in lieu of vacation must be made within two years after the close of the cost reporting period in which the vacation is accrued. If payment is not made within the required period of time or in those instances where the vacation benefits, accrued and included in allowable costs, are forfeited by the employee for cause, the current year cost report must be adjusted.

(c) Amounts allowed for vacation benefits must be reasonable in themselves and, together with other compensation, result in reasonable compensation for services rendered.

(d) Employer payroll taxes applicable to vacation, such as FICA, must not be accrued, but treated as a cost in the period when the vacation costs are paid.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.09. Travel Expense

(1) Travel expense incurred by a facility to send employees (except physicians, which is covered below) to attend a required educational workshop within the state which increases the quality of medical care and/or the operating efficiency of the facility is an allowable cost. Workshops on medical techniques, health applications, data processing, clinic accounting and cost finding, and other administrative activities are examples of the types of workshops for which travel expense will be recognized. Travel expense incurred by a facility to send physician employees to attend educational workshops for licensure requirements is an allowable cost if the workshop is held within the state. Any physician educational costs above the licensure requirements is an unallowable cost. Travel that is necessary and that is directly related to the operation of the clinic claiming reimbursement for the expense will be an allowable cost for reimbursement purposes pursuant to the following specific provisions.

(a) Automobile

1. Reimbursement will be based on a standard mileage rate and will be limited to mileage which is documented by log entries prepared in accordance with either of the attached sample logs. (See Schedules 9A and 9B found at end of chapter.) Reimbursement to employees for the use of their personal vehicles will be limited to the lesser of the actual reimbursement to the employee or the standard mileage rate per section (1)(a)3 of this rule.

All log entries must be made at the time of travel, and log entries will be subject to verification during audit. Failure to timely and accurately account for travel mileage will result in a disallowance of this cost.

2. Commuting mileage between the commuter's residence and the FQHC is not allowable mileage for reimbursement purposes. Non-patient care travel is also not allowable.

3. The standard mileage rate is as follows: The IRS mileage rates in effect on January 1 of the calendar year in which the cost report is filed (January 1, 1991 for cost reports filed as of September 30, 1991). These rates will be applied on a per provider basis regardless of the number or type of vehicles used.

4. No reimbursement will be made or considered for unusual or impractical vehicles, which include but are not limited to aircraft, motorcycles, farm equipment and other vehicles not necessary to the efficient operation of the center. Vehicles used as clinics to provide for the delivery of Health Services for the Homeless, under the direction of Public Health Grant 340, will not be reimbursed mileage; but, will be reimbursed for gas, oil, depreciation, interest, insurance, taxes, and repair and maintenance.

(b) Other Travel

1. Costs of travel to out-of-state conventions or association meetings will be limited to those reasonable costs incurred by a center for two trips during each fiscal year. If the center bears the expenses of two persons attending the same convention or association meeting, such attendance will be counted as two trips. Reimbursement will be considered only for bona fide employees of the center whose attendance will benefit the operation of the center. Expenses related to travel expenses of employee spouses will not be eligible for reimbursement unless the spouse is a bona fide employee of the facility and has a legitimate reason, related to patient care, for such attendance. Since only patient care related travel is allowable, evidence must be on file to verify that the travel was patient related. Such evidence may be: (a) seminar registration receipts, (b) continuing education certificates, or (c) similar documentation. If verification cannot be made, reimbursement will not be allowed. Out-of-state travel living expenses will be limited to \$125.00 per day for the length of the functions attended. Per diem for the date of return will be limited to \$50.00 because lodging is not required.

2. Travel expenses in or out-of-state will be limited to the ordinary and necessary costs of transportation, food, lodging, and required registration fees.

3. Whenever out-of-state travel could be accomplished at a lower cost by utilizing air travel, reimbursement will be limited to the costs which would have been incurred if such air travel had been utilized and the costs normally incident to such air travel (meals, lodging, etc.).

4. No travel expenses of a nonbusiness nature will be reimbursed.

5. Travel which requires an overnight stay must be documented by a travel voucher which includes the following:

(i) Date

(ii) Name of person

(iii) Destination

(iv) Business purpose

(v) Actual cost of meals and lodging (lodging must be supported by invoices, meal receipts must indicate number of meals served for any meal in excess of \$10.00).

(vi) Air, rail and bus fares (supported by an invoice)

(2) Travel associated with political activities or lobbying efforts is not allowable. This type of travel is not directly related to patient care.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.10. Property Costs

(1) General Principles Relating to Property Costs. Property Costs include, but are not limited to, depreciation, interest, lease and rental payments, insurance on buildings and contents, and property taxes. In addition to the limitations contained in this rule, all property costs will be subject to the "prudent buyer" concept with each case to be considered on its own merit. Also, depreciation, interest, rent, insurance, and taxes associated with space and equipment used for non-covered services or activities must be eliminated from allowable property costs.

(2) Depreciation

(a) Depreciation is that amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period or operation. The amount of depreciation is determined by using the straight line method.

(b) The principles of reimbursement for facility costs provide that payment for services should include depreciation on all depreciable type assets that are used to provide covered services to beneficiaries. This includes assets that may have been fully (or partially) depreciated on the books for the facility but are in use at the time the facility enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on a revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity. An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be: (1) identifiable and recorded in the facility's accounting records; (b) based on the historical cost of the asset or fair market value at the time of donation or inheritance, in the case of donated or inherited assets; and (c) prorated over the estimated useful life of the asset using the straight line method of depreciation.

(c) Depreciable Assets. Assets that a facility has an economic interest in through ownership regardless of the manner in which they were acquired, are subject to depreciation. Generally, depreciation is allowable on the assets described below when required in the regular course of providing patient care. Assets which a facility is using under a regular lease arrangement would not be subject to depreciation by the facility.

(d) Buildings. Buildings include, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

(e) Building Equipment. Building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc. The general characteristics of this equipment are: (1) affixed to the building, and not subject to transfer; and (2) a fairly long life, but shorter than the life of the building to which affixed. Since the useful lives of such equipment are shorter than those

of the buildings, the equipment may be separated from building cost and depreciated over this shorter useful life.

(f) Major Moveable Equipment. Major moveable equipment includes such items as accounting machines, beds, wheelchairs, desks, vehicles, X-ray machines, etc. The general characteristics of this equipment are: (1) a relatively fixed location in the building; (2) capable of being moved as distinguished from building equipment; (3) a unit cost sufficient to justify ledger control; (4) sufficient size and identity to make control feasible by means of identification tags; and (5) a minimum life of approximately three years.

(g) Minor Equipment. Minor equipment must be expensed as of the date of purchase. Minor equipment includes such items as waste baskets, syringes, catheters, mops, buckets, etc. The general characteristics of this equipment are: (1) in general, no fixed location and subject to use by various departments of the facility; (2) comparatively small in size and unit cost; (3) subject to inventory control; (4) fairly large quantity in use; and (5) generally, a useful life of approximately three years or less.

(h) Land (Non-depreciable). Land (non-depreciable) includes the land owned and used in facility operations. Included in the cost of land are the costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the facility, and other land expenditures of a non-depreciable nature.

(i) Land Improvements (Depreciable). Depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the facility).

(j) Lease Hold Improvements. Lease hold improvements include betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

(k) Accounting Records. The depreciation allowance, to be acceptable, must be adequately supported by the facility's accounting records. Appropriate recording of depreciation requires the identification of the depreciable assets in use, the assets' historical cost (or fair market value at the time of donation in case of donated assets), the method of depreciation, and the assets' accumulated depreciation.

(l) Useful Life of Depreciable Assets. The depreciable life of an asset is its expected useful life to the facility; not necessarily the inherent useful or physical life. The useful life is determined in light of the facilities experience and the general nature of the asset and other pertinent data. Some factors for consideration are: (1) normal wear and tear, (2) obsolescence due to normal economic and technological advances, (3) climatic and other local conditions, and (4) facility's policy for repairs and replacement. In projecting a useful life, facilities are to follow the useful life guidelines published by the American Hospital Association (See Schedule at end of Chapter). The agency may allow lives different from these guidelines, if the provider requests consideration in writing. However, the deviation must be based on convincing reasons supported by adequate documentation, generally describing the realization of some unexpected event. Factors such as an expected earlier sale, retirement or demolition of an asset may not enter into a determination of the expected useful life of an asset.

(m) Acquisitions. If a depreciable asset has at the time of its acquisition an estimated useful life of at least two (2) years and a historical cost of at least \$300, or, if it is acquired in quantity and the cost of the quantity is at least \$500, its cost must be capitalized, and written off ratably over the estimated useful life of the asset. If a depreciable asset has a historical cost of less than \$300 or, if it is acquired in quantity and the cost of the quantity is less than \$500 or if the asset has a useful life less than two (2) years, its cost is allowable in the year it is acquired. The facility may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the above criteria be exceeded.

(n) Determining Depreciation in Year of Acquisition and Disposal. The amount of depreciation recorded during the year of acquisition and year of disposal varies among centers. The following methods are acceptable for computing first and last year depreciation amounts. Any other method for computing first and last year depreciation must be approved by the Medicaid Agency. Whatever method is adopted, it must be applied to all assets subsequently acquired.

1. Time Lag Alternatives. These result in delayed recording of depreciation after the actual date of acquisition. However, they provide the convenience of updating detailed, supportive accounting records at the end of certain time intervals.

(i) Up to Six Months Lag. Assets acquired during the first six months of the reporting year are subject to depreciation beginning with the first day of the seventh month of the reporting year. Assets acquired during the second six months of the reporting year are subject to depreciation beginning with the first day of the subsequent reporting year. Depreciation on disposal is based on the portion of the year in which the asset is disposed. If the asset is disposed of in the first half of the reporting year, one-half year's depreciation is taken. If the asset is disposed of in the second half of the year, a full year's depreciation is taken.

(ii) Up to One Year Time Lag. Assets acquired during the reporting year become effective for depreciation on the first day of the subsequent reporting year. In the year of disposal a full year's depreciation is taken.

2. Half Year Depreciation. One-half year depreciation is taken in the year of acquisition regardless of acquisition date and one-half year depreciation is taken on disposition regardless of disposition date.

3. Actual Time Depreciation. Depreciation for the first reporting period is based on the length of time from the date of acquisition to the end of the reporting year. Depreciation on disposal is based on the length of time from the beginning of the reporting year in which the asset was disposed to the date of disposal.

(o) Disposal of Assets. Depreciable assets may be disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, fire or other casualty. In such cases, depreciation can no longer be taken on the asset, and gain or loss on the disposition must be computed. Where an asset has been retired from active service, but is being held for standby or emergency services, depreciation may continue to be taken on such assets. However, where asset has been permanently retired, or there is little or no likelihood that it can be effectively used in the future, no further depreciation can be taken on the asset. In such case, gain or loss on the retirement must be computed.

(3) Interest

(a) Necessary and reasonable interest expense on both current and capital indebtedness is an allowable cost. Interest is the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term, usually for one (1) year or less. Current borrowing is usually for purposes such as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as the acquisition of facilities, equipment, and capital improvements. Generally, loans for capital purposes are long-term loans. Interest is usually expressed as a percentage of the principal. Sometimes, it is identified as a separate item of cost in a loan agreement. Interest may be included in "finance charges" imposed by some lending institutions or it may be a prepaid cost or "discount" in transactions with those lenders who collect the full interest charges when funds are borrowed. Reasonable finance charges and service charges together with interest on indebtedness are includable in allowable cost. To be allowable, interest must be: (1) supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required; (2) identifiable in the facilities accounting records; (3) related to the reporting period in which the costs are incurred; and (4) necessary and proper for the operation, maintenance, or acquisition of the center's facilities. To support the existence of a loan, the facility should have available a signed copy of the loan contract which should contain the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc. Where the lender does not customarily furnish a copy of the loan contract, correspondence from the lender stating the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc., will be acceptable. Various methods of identifying and accounting for interest costs are used. These include periodic cash payments of interest with or without repayment of all or part of the loan; prepayment of interest when the liability is incurred with charges to interest expense recorded in relation to the accounting period; and accrual of interest with no cash payment with a corresponding record of the unpaid liability reflected in the accounting records. The method actually used depends on the type of loan and the terms of the loan agreement. Where interest expense has been determined to be allowable and the interest expense records are maintained physically away from the facility premises such as in a county treasurer's office, such records will be deemed to be those of the facility. This would be applicable where bond issues have been specifically designated for the construction or acquisition of the centers facilities and the financial records relative to the bond issue are maintained by some governmental body other than the facility.

(b) Necessary Interest. Necessary means that the interest be incurred on a loan made to satisfy a financial need of the facility and for a purpose reasonably related to patient care. For example, where funds are borrowed for purposes of investing in other than the facility's operations, interest expense is not allowable, such a loan is not considered "necessary." Likewise, when borrowed funds create excess working capital, interest expense on such borrowed funds is not an allowable cost. Necessary also requires that the interest be reduced by investment income. There is an exception to this general rule where the investment income is from grants and gifts, whether restricted or unrestricted, and which are not commingled with other funds. "Not commingled" means

that the funds are kept physically apart in a separate bank account and not simply recorded separately in the facility's accounting records.

(c) Proper Interest. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arms-length transaction in the money market when the loan was made. In addition, the interest must be paid to a lender not related to the facility through common ownership or control.

(d) Mortgage Interest. A mortgage is a lien on assets given by a borrower to a lender as security for borrowed funds for which payment will be made over an extended period of time. Mortgage interest refers to the interest expense incurred by the borrower on a loan which is secured by a mortgage. Usually such loans are long-term loans for the acquisition of land, buildings, equipment, or other fixed assets. Mortgage loans are customarily liquidated by means of periodic payments, usually monthly, over the term of the mortgage. The periodic payments usually cover both interest and principal. That portion which is for the payment of interest for the period is allowable as a cost of the reporting period to which it is applicable. In addition to interest expense, other expenses are incurred in connection with mortgage transactions. These may include attorney's fees, recording costs, transfer taxes and service charges which include finder's fees and placement fees. These costs, to the extent that they are reasonable, should be amortized over the life of the mortgage in the same manner as bond expenses. The portion applicable to the reporting year is an allowable cost.

(e) Interest During Period of Construction. Frequently, centers may borrow funds to construct facilities or to enlarge existing facilities. Usually, construction of facilities will extend over a long period of time, during which interest costs on the loan are incurred. Interest costs incurred during the period of construction must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care. If the construction is an addition to an existing facility, interest incurred during the construction period on funds borrowed to construct the addition must be capitalized as a cost of the addition. After the construction period, interest on the loan is allowable as an operating cost.

(f) Interest on Notes. A note is the contractual evidence given by a borrower to a lender that funds have been borrowed and which states the terms for repayment. Interest on notes is allowable as a cost in accordance with the terms of the note. Frequently, a note is issued as an instrument evidencing a loan which may have a term running several years. The interest on such a loan is incurred over the period of the loan. Under the accrual method of accounting, the interest cost incurred in each reporting period is an allowable cost in the applicable reporting period. If, under the terms of the loan, the interest is deducted when the loan is made (discounted), the interest deducted should be recorded as prepaid interest. A proportionate part of the prepaid interest is allowable as cost in the periods over which the loan extends.

(4) Sale and Lease back and Lease-Purchase Agreements.

(a) Sale and Lease back Agreements - Rental Charges. Where a facility enters into a sale and lease back agreement with a non-related purchaser involving plant facilities or equipment, the incurred rental specified in the agreement is includable in allowable cost if the following conditions are met:

1. The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition and value of the facilities or equipment rented and other provisions of the rental agreements;

2. Adequate alternate facilities or equipment which would serve the purpose are not or were not available at lower cost; and

3. The leasing was based on economic and technical considerations.

If all these conditions were not met, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs had he retained legal title to the facilities or equipment, such as interest or mortgage, taxes, depreciation, insurance and maintenance costs.

(b) Lease Purchase Agreement - Rental Charges.

1. Definition of Virtual Purchase. Some lease agreements are essentially the same as installment purchases of facilities or equipment. The existence of the following conditions will generally establish that a lease is a virtual purchase:

(i) The rental charge exceeds rental charges of comparable facilities or equipment in the area;

(ii) The term of the lease is less than the useful life of the facilities or equipment; and

(iii) The center has the option to renew the lease at a significantly reduced rental, or the center has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the center is permitted.

2. Treatment of Rental Charges. If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased. If the asset is returned to the owner, instead of being purchased, the deferred charge may be expensed in the year the asset is returned. Where the term of the lease is extended for an additional period of time, at a reduced lease cost, and the option to purchase still exists, the deferred charge may be expensed to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership. On the other hand, if the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be expensed to the extent of increasing the reduced rental to a fair rental value.

(5) Allowance for Depreciation on Facilities Leased for a Nominal Amount.

(a) Some centers might lease their facilities from municipalities at a nominal rental (usually for \$1.00 per year) and the lease generally covers the useful life of the facility. Under most lease arrangements the tenant (lessee) maintains the property and pays the cost of any improvement or addition to the facility. When such improvement or addition is made the lessee may properly amortize its cost. The amortization allowance is includable in allowable cost. At the end of the lease, improvements and additions made

by the lessee become the property of the lessor. However, in some instances the lease agreement provides that title to any additions or improvements is to revert to the owner in the first year they are used. In such cases, the cost of any addition or improvement would be similarly amortized and the amortization allowance would also be includable in allowable cost. It is the general practice of the center to include its charges (and cost) an amount to cover depreciation on the leased facilities as distinguished from capital improvements made by the lessee. In recognition of this practice, most third parties that reimburse centers on the basis of cost allowed depreciation (but not interest) on facilities that have been leased for a nominal rental. In view of this and since this type lease arrangement in such cases generally contemplates the occupancy by the lessee for the period of the useful life of the facility, depreciation on the leased facility may be included in allowable cost under the conditions described below.

(b) Analysis of Lease Arrangement. Each case must be decided on its own merit for depreciation to be allowed. The lease must contemplate that the lessee will make any necessary improvements and will properly maintain the facility. The lease may and frequently does cover the useful life of the asset; if not, however, as in the case of the year to year lease, such lease should be examined closely to determine whether the renewal and other provisions of the lease contemplate that the center will use the facility to the extent of its useful life. Where the intent and provisions of the year to year lease permit the center to have the benefit of the useful life of the facility, such lease should be treated, for depreciation purposes, in the same manner as a long-term lease that covers the useful life of the asset. The actions of the lessee and lessor in such cases should indicate that the intent of both parties is to continue the lease arrangements for the useful life of the asset. Of course, other facts should be considered together with the past actions of the lessee and lessor in order to determine whether or not the asset will and can be used by the lessee for the asset's full useful life. The lease should have no restrictions on the free use of the facility by the lessee. In addition, the lease should not provide for any indirect benefits to the lessor or to those connected with the lessor. For example, if the lease requires that the lessee furnish free clinic services to the employees of the lessor, then depreciation should not be allowed. In such cases, the cost of the services furnished to the lessor's employees would be appropriately included when determining allowable costs.

(6) Equipment Rental. Reasonable costs of such rental equipment as is normally and traditionally rented by health care institutions and which is rented from a non-related organization, are allowable provided the arrangement does not constitute a lease-purchase agreement. All items leased under a lease-purchase agreement must be capitalized and depreciated over the useful life of the asset.

(7) Insurance on Building and Contents. The reasonable costs of insurance on buildings and their contents used in rendition of covered services purchased from a commercial carrier and not from a limited purpose insurer (Ref. HIM-15, Section 2162(2)) will be considered as allowable costs.

(8) Property Taxes. Ad valorem and personal property taxes on property used in the rendition of covered services are allowable under this section. Fines, penalties or interest related to those taxes are not allowable.

(9) Life and Rental Insurance. Premium payments for life insurance required by a lender or otherwise required pursuant to a financing arrangement will not be an allowable cost. Loss of rental insurance will also be considered an unallowable cost.

(10) Donation of the use of space. An FQHC may receive a donation of the use of space by another organization. In such case, the FQHC may NOT impute a cost for the value of the use of space and include the imputed cost in allowable costs. The FQHC can include in the allowable costs of the FQHC, items such as costs of janitorial services, maintenance, repairs, etc., if used full time by the FQHC for patient related care and paid for by the FQHC.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.11. Costs to Related Parties

(1) Allowable costs incurred by a provider for services or goods provided by Related Parties will not exceed the net cost of the services or goods to that Related Party, and that cost cannot exceed the fair market value of the items or services involved.

(2) Under no circumstances will rent paid to a Related Party be includable in allowable costs. In such cases, lessor's costs may be included in allowable costs provided that such costs do not exceed the fair market value of the leased assets.

(3) The provisions of HIM-15 shall be applicable in determining whether a Related Party relationship exists.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.12. Chain Operations

A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A

chain organization may also include business organizations which are engaged in other activities not directly related to health care.

The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicaid program is that of a related organization to participating facilities. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services management direction and control, and other services. To the extent the home office furnishes services related to patient care to a facility, the reasonable costs of such services are includable in the facility's cost report and are reimbursable as part of the facility's costs. Where the home office of the chain provides no services related to patient care, no home office cost may be recognized in determining the allowable costs of the facilities in the chain.

Very often the home office of a chain organization charges the facility in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, and such fees must be deleted from the facility's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the facility.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.13. Unallowable Expenses

(1) General

(a) All payments to providers for services rendered must be based on the reasonable cost of such services covered by the Alabama State Plan. It is the intent of the program that providers will be reimbursed the reasonable costs which must be incurred in providing quality patient care. Implicit in the intent that reasonable costs be paid are the expectations that the provider seeks to minimize costs and that costs do not exceed what a prudent and cost-conscious buyer pays for a given item of service or product. If costs are determined to exceed the level that prudent buyers incur in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not allowable.

(b) Costs related to patient care include necessary and proper costs involved in developing and maintaining the efficient operation of patient care facilities. Necessary and proper costs related to patient care are those which are usual and accepted expenses of similar providers.

(2) Overhead costs which will not be allowed are listed below. This listing is not intended to be all inclusive. Other overhead costs which violate the prudent buyer concept or are not related to patient care will not be reimbursed by the Alabama Medicaid Agency.

(a) Management Fees. Management firms, individuals and consultants which duplicate services already provided, or in a clinic in which a full-time administrator is employed. Excluded from this rule are those management contracts required incident to a bond issue for a valid business purpose.

(b) Director's Fees

(c) Compensation to owners and other personnel not performing necessary functions

(d) Salaries which are paid to personnel performing overlapping or duplicate functions

(e) Legal Fees and Expenses

1. Retainers

2. Relating to informal conferences and fair hearings

3. Relating to issuance and sale of capital stock and other securities

4. Relating to creation of corporations or partnerships

5. Relating to business reorganization

6. Services for benefits of stockholders

7. Acquisition of clinics or other business enterprises

8. Relating to sale of clinics and other enterprises

9. In connection with criminal actions resulting in a finding of guilt or equivalent action or plea

10. Other legal services not related to patient care

(f) Outside Accounting and Audit Fees and Expenses

1. Personal tax returns

2. Retainers

3. Relating to informal conferences and fair hearings

4. Relating to issuance and sale of capital stock and other securities

5. Relating to creation of corporations or partnerships

6. Relating to business reorganization

7. Services for the benefits of stockholders

8. Acquisition for clinics or other business enterprises

9. Relating to sale of clinics and other enterprises

10. In connection with participation in criminal actions resulting in guilt or equivalent action or plea

11. Other accounting services not related to patient care

(g) Taxes

1. Personal income

2. Property not related to patient care

3. Corporate income tax

4. Vehicle tag & tax

(h) Dues

1. Club

2. Civic

3. Social

4. Professional organization dues for individuals

5. Non-patient care related organization

(i) Insurance

1. Life
2. Personal property not used in patient care
3. On real estate not used in providing patient care
4. Group life and health insurance premiums which favor owners of a clinic or are for personnel not bona fide employees of the clinic
- (j) Special assessments from Primary Health Care Association
- (k) Bad debts and associated collection expenses
- (l) Employees relocation expenses
- (m) Penalties
 1. Late Tax
 2. Late payment charges. (None: If a clinic can fully document that a late payment charge is directly due to late Medicaid payments, the amount of the late payment charge will be an allowable cost.)
 3. Bank overdraft
 4. Fines
- (n) Certain Real Estate Expenses
 1. Appraisals obtained in connection with the sale or lease of a clinic (unless required by Medicaid)
 2. Costs associated with real estate not related to patient care
- (o) Interest Expense
 1. Interest associated with real estate in excess of clinic needs or real estate not related to patient care.
 2. Interest expenses applicable to penalties
 3. Construction Interest (must be capitalized)
 4. Interest paid to a related party
 5. Interest on personal property not related to patient care.
 6. Interest on loans not associated with patient care
- (p) Licenses
 1. Consultants
 2. Professional personnel
- (q) Donations and Contributions
- (r) Accreditation Surveys
- (s) Telephone Services
 1. Mobile telephones, beepers, telephone call relays, automated dialing services
 2. Long distance telephone calls of a personal nature
- (t) Any costs associated with corporate stock records maintenance
- (u) Any expenses associated with political activities or lobbying efforts are not allowable

(3) Prior Period Costs and Accounts Payable

(a) The Medicaid reimbursement rate is calculated to provide adequate funds to pay business expenses in a timely manner. Costs incurred in prior periods but not paid must be accrued and reported in that period during which the costs were incurred. Payment of prior period cost in the current year is not an allowable cost. Exceptions will be allowed, based on reasonableness, for small invoices which, in total, do not exceed

\$500.00 per fiscal period. These invoices must be as a result of no fault of the provider. Any pattern of abuse will cause the costs in question to be automatically disallowed by the Agency.

(b) Short-term liabilities must be paid within ninety (90) days from the date of invoice; otherwise, the expense will not be allowed unless the provider can establish to the satisfaction of Medicaid that the payment was not made during the 90 days for a valid business reason.

(c) Actual payment must be made by cash or negotiable instrument. For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and must be payable to order of or to bearer. All voided instruments, whether voided in fact or by devise, are considered void from inception.

(d) A provider who files for and is awarded protection under Chapter 11 of the Federal Bankruptcy Code may be given consideration in a current year cost report for actual payment of prior period allowable costs which have been disallowed in prior period cost reports due to failure to make actual payment of the cost claimed. In order for payment of these prior year allowable costs to be considered under a current year cost report, they must have been paid pursuant to a court approved plan for reorganization under Chapter 11 of the Federal Bankruptcy Code. The allowable costs will not include any interest or penalty incurred for failure to make payment in prior year. The Agency will not reimburse interest expense generated from loans incurred to pay any such allowable prior period costs. Any such (untrended) allowable cost shall be added to the encounter rate after the normal rate setting process. It will be subject to the 80th percentile ceiling, thus the providers cost must be below the ceiling rate for any possible reimbursement of these prior period costs to occur.

(4) Bad Debts. Bad debts resulting from beneficiaries' failure to pay are to be treated as noncovered costs. Hence, such bad debts cannot be included in a computation of the average cost per encounter.

(5) Research Costs

(a) Costs, incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

(b) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and clinic research needs

(6) Luxury Items or Services

(a) Where clinic operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

(b) Luxury items or services are those that are substantially in excess of or more expensive than the usual items or services rendered within a clinic's operation to the majority of patients.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.14. Accounting Records

(1) The provider must submit adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be presented on the accrual basis of accounting. This basis requires that revenue must be allocated to the accounting period in which it is earned and expenses must be charged to the period in which they are incurred, regardless of when cash is received or disbursed.

(2) Cost and statistical information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for supplies, services, or assets. This includes all ledgers, books, records, and original evidence of costs which pertain to the costs reported. Financial and statistical records should be maintained in a consistent manner from one period to another; however, the regard for consistency should not preclude a desirable change in accounting procedures provided that full disclosure of significant changes is made.

(3) The following records and documentation must be kept by the provider and must be available for audit inspection by Medicaid:

- (a) General Ledger
- (b) Disbursements Journal
- (c) Cash Receipts Journal
- (d) Payroll Journal
- (e) Working Trial Balance and Adjusting Entries
- (f) Patient Records
- (g) Purchases Journal
- (h) Time Sheets

(4) All information contained in the provider's General Ledger must be capable of audit verification. Disbursements must be supported by invoices which detail the quantity and price of goods and services purchased, together with evidence that such goods and/or services were received. Disbursements made without proper documentation will not be allowable for Medicaid reimbursement purposes. This documentation should be filed in chronological order, either alphabetically or in some other reasonable manner capable of being audited. Payroll journals must be supported by time cards or other documentation, such as time sheets, signed by the employee and verified by his/her department head. (Time sheets for physicians can be signed for the physician by the clinic manager.) Each

time card or other documentation must also indicate the hours worked by the employee, the rate of pay for the services rendered by the employee, and must be identified by the cost center, to which the expense should be charged.

(5) Subsidiary records which must be kept by the provider and be readily available for audit and inspection include, but are not limited to:

- (a) Accounts Receivable ledger sheets or cards which agree with the General Ledger control account (to include fiscal year end aging schedules)
- (b) Accounts Payable Ledger sheets or cards which agree with the General Ledger control account (to include fiscal year end aging schedules)
- (c) Notes Receivable
- (d) Notes Payable
- (e) Long-Term Debt evidenced by amortization schedules and copies of the original debt transaction
- (f) Insurance policies together with invoices covering the fiscal year reported
- (g) Depreciation Schedules showing the cost of the facility and equipment
- (h) Payroll Tax Returns
- (i) Income Tax Returns
- (j) Bank Statements, cancelled checks, deposit slips, voided checks, and bank reconciliations
- (k) A signed copy of the current lease
- (l) Automobile travel logs

(6) Petty Cash Funds shall be maintained under the Imprest System. The disbursement of these funds shall be substantiated by an invoice and/or voucher detailing the date of disbursement, expense category, and name of person disbursing the funds.

(7) All documents, work papers, and schedules prepared by or on behalf of the provider which substantiate data in the cost reports must be made available to Medicaid auditors and investigators upon request.

(8) The provider will provide adequate desk space and privacy to Medicaid auditors and investigators during the progress of audits. The provider's personnel or personnel representing an outside independent accountant may be present at a Medicaid audit and be allowed access to the Medicaid auditors and workpapers only at the invitation and discretion of the Medicaid auditors during the course of their work at the provider's establishment.

(9) In the event a Medicaid auditor or investigator is denied access to a provider's records, the provider will be advised of the contract provisions governing inspection and review of these records by authorized representatives. The provider will be advised that if access to records is not granted, the provider will be given ten (10) calendar days in which to furnish the records to Medicaid at its Montgomery offices. If a provider fails to comply within the ten (10) day period, Medicaid will reduce all subsequent reimbursement payments by the costs it has been unable to substantiate.

(10) If the provider fails to keep the minimum financial records required to properly substantiate reported costs, the provider will be subject to termination from the Medicaid program.

(11) All books and records required to be kept and made available to Medicaid personnel by a provider will be made available at the facility unless this requirement is specifically waived in writing, in advance by Medicaid.

(12) If a provider who has been given three (3) full working days notice of an audit fails to make the required records, including any not maintained at the facility, available at that facility, the Medicaid auditor(s) will return to the Medicaid Agency, and the provider will be given ten (10) calendar days to present all of the accounting records at the Medicaid office. Should the provider fail to present all of the accounting records at the Medicaid office during the allotted time period, Medicaid will consider all payments made to the provider during the time period covered by the records sought to be audited to be overpayments and may proceed to recover those overpayments from the provider.

(13) If Medicaid is required to go out of state for an audit, the organization being audited will bear all expenses and costs related to the audit, including, but not limited to, travel and reasonable living expenses, and those costs will not be allowable on any subsequent cost report.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.15. Cost Reports

(1) General – New FQHCs must file a cost report, using Medicaid’s prescribed cost report forms, when (1) submitting an operating budget to establish a budget rate and (2) submitting actual cost to settle the budget period. The due date to submit the cost report to settle the budget period will be given in correspondence to the provider by Medicaid. Each new FQHC will have its own National Provider Identification (NPI) number and file its own cost report. This means that if a provider has five clinics, each with its own Medicare or Medicaid number, five cost reports should be filed using five different NPI numbers. An extension of the due date given by Medicaid may be granted for good cause shown. An extension request must be in writing, contain the reasons for the extension, and must be made prior to the cost report due date. Only one extension, for a maximum of 30 days, will be granted by the Agency.

(2) Penalties. If a complete cost report is not filed by the due date given in correspondence to the provider by Medicaid, or an extension is not requested or granted, the provider shall be charged a penalty of \$100.00 per day for each calendar day after the

due date. This penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting documentation. Once a cost report is late, Medicaid shall suspend payments to the provider until the cost report is received. A cost report that is over 90 days late may result in suspension of the provider from the Medicaid program. Further, the entire amount paid to the provider during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The provider will have 30 days to either refund the overpayment or file the delinquent cost report after which time Medicaid may institute a suit or other action to collect this overpayment amount or the delinquent cost report.

(3) Each cost report will be signed by the administrator or by an officer of the FQHC. The signature must be preceded by the following certification: I HEREBY CERTIFY that I have examined the accompanying worksheets prepared by _____ for the reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief it is a true, correct and complete statement prepared from the books and records of the FQHC in accordance with applicable instructions, except as noted.

Signature (Officer or Administrator) Title Date

(4) Any cost report received by Medicaid without the required original signature and/or without the required certification will be deemed incomplete and returned to the provider.

(5) Cost reports should be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by providers. Cost reports will be deemed immutable with respect to the reimbursement for which the provider is entitled for the next succeeding fiscal year, one year from the date of its receipt by Medicaid, or its due date, whichever is later. Providers will have this one year period within which to resubmit their cost reports for the purpose of correcting any material errors or omissions of fact. This one year limitation does not apply to adjustments in cost reports that are initiated by Medicaid. Medicaid retains the right to make adjustments in cost reports at any time a material error or omission of fact is discovered.

(6) Providers who terminate their participation in the Medicaid program, by whatever means, must provide a written notice to the Agency 30 days in advance of such action. Failure to provide this written notice shall result in a \$100.00 per day penalty being assessed for each day short of the 30-day advance notice period (up to a maximum of \$3,000.00). Terminating providers must file a final cost report within 75 days of terminating their participation in the program. Final payment will not be made by the Medicaid Agency until this report is received. Failure to file this final cost report will result in Medicaid deeming all payments covered by the cost report period as

overpayments until the report is received. Additionally, a penalty of \$100.00 will be assessed for each calendar day that the cost report is late.

Author: Sandra Johnson, Associate Director, Provider Audit, Q/A Reimbursement

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994. **Amended:** Filed September 22, 2008; effective December 17, 2008.

Rule No. 560-X-56-.16. Audit Adjustment Procedures

(1) Audit adjustments will be paid or collected by a combination of (1) changing the encounter rate of the facility and (2) a lump sum settlement for the amount under/over paid for the period prior to the effective date of the encounter rate change.

(2) Under/Overpayment situations arising from the audit of a terminating cost report will be paid or recouped by a lump sum settlement.

(3) All adjustments will be subject to the limitations set out in this Chapter and subject to the appropriate ceilings.

(4) Collection procedures will be applied only after the facility has been given thirty (30) days in which to disagree with any of the disallowances contained in the report of audit.

(5) A final audit computation sheet will be forwarded to each facility with the report of audit. An adjusted encounter rate will be stated in the report of audit and will be computed based on the audit adjustments. This new encounter rate will be effective on the first day of a month, allowing for the thirty (30) day notification period and a reasonable amount of time for processing the report of audit. The effective date of the rate change will be shown on the final audit computation worksheet. The remaining portion of the audit settlement will be collected or paid in a lump sum amount. This lump sum amount for the months prior to the effective date (underpayment or overpayment period) of the rate change is computed by applying the adjustment per encounter to the total paid Medicaid encounters in the overpayment/underpayment period.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.17. Appeals

(1) Facility administrators who disagree with the findings of the Medicaid desk audits or field audits may request, in writing, an informal conference at which they may present their positions. Such written requests must be received by Medicaid within thirty (30) days of the date on which Medicaid mails the audit report, or new encounter rate, as the case may be, to the provider.

(2) Administrators who believe that the results of the informal conference are adverse to their facility may ask, in writing, for a Fair Hearing, which will be conducted in accordance with Medicaid Regulations. Such written requests must be received by Medicaid within fifteen (15) days of the date on which Medicaid mails to the provider its determination on the issues presented at the informal conference.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.18. Negligence and Fraud Penalties

(1) Whenever an overpayment of Medicaid reimbursement received by a provider from Medicaid results from the negligent or intentional disregard of Medicaid Reimbursement Principles by the provider or its representatives (but without intent to defraud), there will be deducted from any reimbursement thereafter due the provider a penalty equal to 5% of such overpayment.

(2) If any part of such an overpayment by Medicaid to the provider is due to fraud on the part of the provider or any of its representatives, there will be deducted from any subsequent reimbursement due the provider on proof of fraud, a penalty equal to 50% of the overpayment.

(3) The penalties imposed under Rules No. 560-X-56-.18(1) and (2) of this Code shall be in addition to and shall in no way affect Medicaid's right to also recover the entire amount of the overpayment caused by the provider's or its representative's negligence or intentional disregard of the Medicaid Reimbursement Principles or fraud.

(4) Whenever the cost of a good or service has been previously disallowed as the result of a desk audit of a provider's cost report and/or a field audit by Medicaid and such cost has not been reinstated by voluntary action of Medicaid as the result of an administrative hearing, or by a court order, such costs shall not thereafter be included as an allowable cost on a Medicaid cost report. The inclusion by the provider or its representative of such a cost on a subsequent cost report, unless the provider is actively pursuing an administrative or judicial review of such disallowance, will be considered as negligent and/or intentional disregard of the Medicaid Reimbursement Principles and subject to the 5% penalty imposed by Rule No. 560-X-56-.18(1) of this Code based upon

the amount of overpayment which has or which would have resulted from the inclusion of such cost had its inclusion not been detected. Such inclusion shall also be subject to the provisions of Rule No. 560-X-56-.19 relating to intentional or negligent disregard of the Medicaid Reimbursement Principles.

(5) For purposes of the preceding paragraph, a provider shall be considered as having included a previously disallowed cost on a subsequent year's cost report if the cost included is attributable to the same type good or service under substantially the same circumstances as that which resulted in the previous disallowance. Examples of such prohibited inclusions include, but are not limited to:

(a) Inclusion of the portion of rental payment previously disallowed as being between related parties.

(b) Inclusion of an amount of compensation which has previously been disallowed as unreasonable during a prior period.

(c) Inclusion of a cost not related to patient care which has previously been disallowed.

(d) Improper classification or allocation of costs to cost centers.

(6) Rule No. 560-X-56-.18(4) shall NOT be interpreted as indicating that a provider's or his representative's initial entry of a cost item on a cost report will not be treated as a negligent or intentional disregard of the Medicaid Reimbursement Principles.

(7) Any provider who knowingly files or allows to be filed a cost report which has been prepared by a person who has been suspended as a Cost Report Preparer during his period of suspension, shall be subject to termination of its contract, and, in addition, subsequent reimbursement otherwise due the provider shall be reduced by \$3,000.00, as though the cost report had not been received by Medicaid during the first thirty (30) day period following the due date for filing such report. (See Rule 560-X-56-.15.)

(8) Providers and their representatives who are uncertain as to whether the inclusion of a cost in a cost report is in violation of the Medicaid Reimbursement Principles should footnote or otherwise call attention to the entry in question and specifically disclose the dollar amount and the portion of the cost report entry as to which they are in doubt.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-56-.19. Cost Report Preparers

(1) Cost Report Preparers. "Cost Report Preparer" includes any person (including a partnership or corporation) who, in return for compensation, prepares or employs another to prepare all or a substantial portion of a Medicaid cost report. A Cost Report Preparer can include both the actual preparer of the report as well as his or her employer. Where

more than one person aids in filling out a Medicaid cost report, the one who has primary responsibility for the preparation of the report will usually be a preparer, while those involved only with individual portions of the report will usually not be preparers. Any person who supplies enough information and advice so that the actual completion of the return is a mere mechanical or clerical matter is a Cost Report Preparer even though the person doesn't actually place or review the placement of the information on the cost report.

(2) Refusal of Cost Reports. Medicaid will refuse to accept cost reports prepared by a Cost Report Preparer who:

(a) Has shown a pattern of negligent disregard of the principles established by or incorporated by reference into this Code;

(b) Prepares a cost report evidencing an intentional disregard of the Medicaid Reimbursement Principles;

(c) Has given false or misleading information, or participated in giving false or misleading information to any Medicaid employee, the Alabama Medicaid Agency, or to any hearing officer authorized to conduct hearings with regard to Medicaid reimbursement issues, knowing such information to be false or misleading.

"Information" includes facts or other information contained in testimony, Medicaid Cost Reports, financial statements, affidavits, declarations, or any other documents or statements, written or oral.

(d) Medicaid will treat any cost report prepared by a Cost Report Preparer who has been determined to be ineligible to prepare Medicaid cost reports as incomplete and shall promptly return such Cost Report to the provider on whose behalf the report has been prepared. The receipt by Medicaid of such cost reports shall not satisfy, suspend, or stay the requirements of this Chapter relating to the timely filing of Medicaid Cost Reports.

(3) Determination of Eligibility.

(a) Upon receipt by any Medicaid employee of information indicating that a Cost Report Preparer may have engaged in conduct which could result in the refusal by Medicaid to accept cost reports prepared by such preparer under Rule No. 560-X-56-.19(2) of this Section, such information shall be promptly reported to Medicaid's Director of Provider Audit who shall insure that an informal inquiry is made regarding the reliability of such information. Medicaid legal counsel and/or appropriate representatives of the Attorney General's office shall be consulted, as deemed appropriate.

(b) Informal Inquiry.

1. If the Medicaid Director of Provider Audit, based upon such informal inquiry, determines that there is substantial evidence that the preparer has engaged in conduct specified in Rule No. 560-X-56-.18, he will give written notice to the preparer which will offer the preparer the opportunity to refute such information or allegations. If the preparer fails to provide the Director of Provider Audit with information which results in a determination by the Director that the evidence of misconduct is insufficient to justify suspension, the Director will, at the preparer's request, have a hearing arranged and will have the preparer notified that such an administrative hearing will be held with regard to the alleged misconduct.

2. Should the preparer fail to deny or provide documentation or information to refute the allegations made against him within thirty (30) days after the date of the mailing of the initial letter to the preparer, such allegations will be deemed to be admitted, and the preparer will have waived his right of hearing. The Director of Provider Audit will then notify the preparer of his suspension under this rule.

3. The above described hearing will be set for a time no earlier than thirty (30) days after the date of the mailing of the initial letter to the preparer.

(c) Procedures Related to Informal Inquiry.

1. Notice. The initial notice from the Director of Provider Audit to the preparer will describe with sufficient specificity the allegations being made against him to allow him to respond to those allegations in a specific manner.

2. The Notice of Hearing. The notice of hearing to the preparer will repeat the allegations which constitute the basis for the proceedings and state the date, time, and place of the hearing. The hearing, as noted in Rule No. 560-X-56-.19(3)(b)1 above will be arranged only at the request of the preparer. Such notice shall be considered sufficient if it fairly informs the preparer of the allegations against him so that he is able to prepare his defense. Such notice may be mailed to the preparer by first class or certified mail, addressed to him at his last address known to the Director of Provider Audit. A response or correspondence from the preparer or his representative shall be mailed to Director of Provider Audit, Alabama Medicaid Agency at the Agency's current address.

3. Answer. No written answer to the notice of hearing shall be required of the preparer.

4. Hearing. The hearing shall be conducted in accordance with Medicaid's Regulations related to Fair Hearings. (Chapter 3 of the Alabama Medicaid Administrative Code.)

5. Failure to Appear. If the preparer fails to appear at the hearing after notice of the hearing has been sent to him, he shall have waived the right to a hearing and the Commissioner of Medicaid may make his or her determination without further proceedings.

6. Determination of ineligibility. The determination of the ineligibility of a Cost Report Preparer to prepare Medicaid cost reports will lie solely with the Commissioner of Medicaid. The Commissioner will make such determination after giving due consideration to the written recommendation of the Hearing Officer, unless the preparer has waived his right to hearing, in which event there need be no recommendation by the Hearing Officer.

7. Notification of Ineligibility. If the determination of the Commissioner is that the preparer shall no longer be eligible to prepare Medicaid cost reports, the preparer shall be notified in writing, and the preparer shall thereafter not be eligible to prepare such reports unless and until authorized by the Commissioner of Medicaid to do so. Such preparer shall IN NO EVENT be eligible to prepare such cost reports during the two (2) year period immediately following his suspension. Any person who acts as a Cost Report Preparer during his period of suspension shall not thereafter be eligible to act as a Cost Report Preparer for a period of ten (10) years from the date of his original suspension. Any provider who knowingly allows a cost report to be prepared by a person who has been suspended under this Section will be subject to having its provider agreement

cancelled and will be subject to the applicable penalties of Rule No. 560-X-56-.18 of this code.

Author: Keith Boswell, Director, Provider Audit.

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act, 42 CFR Sections 405.2460 - .2472 and 447.371.

History: Rule effective April 15, 1993. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.