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State/Territory Name: Alabama

State Plan Amendment (SPA) #: 20-0015

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

April 13, 2021

Ms. Stephanie McGee Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

RE: State Plan Amendment (SPA) 20-0015

Dear Ms. Azar:

We have reviewed the proposed amendment to Attachments 4.19-D of your Medicaid State plan submitted under transmittal number 20-0015. The primary purpose for this amendment is to increase the Current Asset Value for Nursing Facilities to account for the increased costs of Nursing Facilities and to provide parameters for the Quality Incentive Add-on Payment to Nursing Facilities. These changes will become effective on October 1, 2020.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of October 1, 2020. We are enclosing the CMS-179 (HCFA-179) and the amended approved plan pages.

If you have any questions, please call Christie Erickson at (410)786-8441.

Sincerely,

[redacted]

For
Rory Howe
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: AL-20-0015

2. STATE: Alabama

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

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

4. PROPOSED EFFECTIVE DATE
October 1, 2020

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 431.11

7. FEDERAL BUDGET IMPACT:
a. FFY 2020 0 (See Block 23 below)
b. FFY 2021 $18,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, Page 8.1
Attachment 4.19-D, Page 10.a
Attachment 4.19-D, Page 10.b
Attachment 4.19-D, Page 10.c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION

Attachment 4.10-D, Page 8.1
Attachment 4.19-D, Page 10.a

10. SUBJECT OF AMENDMENT:
The primary purpose for this amendment is to increase the Current Asset value for Nursing Facilities to account for the increased costs of Nursing Facilities and to provide parameters for the Quality Incentive Add-on Payment to Nursing Facilities.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor's designee on file via letter with CMS

[redacted] ICIAL:

13. TYPED NAME:
Stephanie McGee Azar

14. TITLE:
Commissioner

15. DATE SUBMITTED: 10/28/20

16. RETURN TO:
Stephanie McGee Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
10/28/20

18. DATE APPROVED:
4/13/21

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted] For

21. TYPED NAME:
Rory Howe

22. TITLE:
Acting Director, Financial Management Group

23. REMARKS:

The state has authorized the following pen and ink changes as noted below:

Block 7: replace with "a. FFY 2021 $17,727,870 b. FFY 2022 $18,448,092"

Block 8 and 9: Remove Attachment 4.19-D Page 10.a.

will be divided by reported patients days. These costs per patient day will be arrayed and a median cost per patient day will be determined. The ceiling for indirect patient care costs is the median cost per patient day plus 10 percent. The providers actual allowable reported cost per patient day plus 50 percent of the difference between actual allowable cost and the established ceiling up to the ceiling amount, will be used for each provider's rate computation.

Ceilings are determined annually based upon allowable cost submitted in the Alabama Medicaid Nursing Home cost reports ending June 30th of each year.

(d) Property Cost - Property costs will be reimbursed under a fair rental system as set out in the Nursing Facility Reimbursement Chapter (Chapter 22) of the Alabama Medicaid Agency Administrative Code. Facilities categorized as NF/IMD will be reimbursed a usage allowance of 2% for building values and 6 2/3% for equipment instead of the fair rental.

Current Asset Values (CAV) for Nursing Homes are based upon historical data rebased annually using Marshall Swift Evaluation. Effective October 1, 2020, the CAV will be increased by 41.03% due to increased costs of Nursing Homes. Allowable interest expense, property taxes and property insurance are determined from the annual Alabama Medicaid Nursing Home cost report ending June 30th of each year or the latest available cost report.

(e) Reimbursement will be the sum of these cost groupings as adjusted under the provisions of Chapter 22 of the Alabama Medicaid Agency Administrative Code.

Allowable cost is determined based upon the annual Alabama Medicaid Nursing Home cost report ending June 30th of each year of the latest available cost report.

Effective Date: 10/01/20

E. A Quality Incentive Add-on payment will be distributed to nursing homes annually.

Quality Incentive Component
For each measure, a provider is awarded points. The points are adjusted based on provider total Medicaid patient days and the resulting adjusted point value is used to determine a provider's portion of Quality Incentive funds.

Process Measures
For each process measure, each provider will be ranked and points will be awarded based on the percentage in which the provider scores in relation to the national average for the measure. For each rate period, the process measures will be calculated using the most recent four quarter average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of July 1 of the year in which the rate period begins.

1. Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine
2. Percentage of long-stay residents assessed and appropriately given the seasonal pneumococcal vaccine
3. Percentage of long-stay residents who received an antipsychotic medication

Outcome Measures
For each outcome measure, each provider will be ranked and points will be awarded based on the percentage in which the provider scores in relation to the national average for the measure. For each rate period, the outcome measures will be calculated using the most recent four quarter average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of July 1 of the year in which the rate period begins.

1. Percentage of long-stay residents who were physically restrained
2. Percentage of SNF residents with pressure ulcers that are new or worsened

The customer satisfaction process measure will be calculated as reported on the most recent Satisfaction Survey Summary Report as prepared by NRC Health. The survey measure will evaluate the combined Resident and Family response to the "Willingness to Recommend" survey element. For Year One of the Quality Incentive the Agency will only evaluate the response rate of the combined Resident and Family surveys. Starting with Year Two the points will be based on actual survey results.

Quality Incentive Add-Ons

1. To be eligible for the Quality Incentive a facility must:
   a. Accept Medicaid recipients;
   b. Participated and completed the most recent Satisfaction Survey by NRC Health; and
   c. Earned a minimum of four (4) points based on the below criteria.

2. Points are awarded to a provider for each quality measure using the following criteria:

Process Measures	0.75 points	1 point	2 points	3 points	Max Points Per Provider
Flu Vaccine	*10% year over year improvement	N/A	N/A	At or Above the National Average	3
Pneumonia Vaccine	*10% year over year improvement	N/A	N/A	At or Above the National Average	3
Antipsychotic	*10% year over year improvement	At or Above the National Average	20% Above the National Average	40% Above the National Average	3

Outcome Measures	0.75 points	1 point	2 points	3 points	Max Points Per Provider
Restraints	*10% year over year improvement	N/A	N/A	At or Above the National Average	3
Pressure Ulcers	*10% year over year improvement	At or Above the National Average	5% Above the National Average	10% Above the National Average	3
Customer Satisfaction – Recommendation**	N/A	Improve TopBox Excellent score by 5-points from previous year.	Exceed National Average for Top3Box Excellent, Very Good, Good Score	Exceed National Average for TopBox Excellent Score	3

**Year over Year improvement is calculated as the change from the year preceding the current year to the current year measurement. For Year One there will be no calculation for annual improvement as it will be considered the Baseline Year performance.*
***For Year One of the Quality Incentive the facility must achieve a combined response rate of thirty percent (30%) on the Resident and Family surveys. If the response rate is achieved the Facility will receive three points. If the response rate is not met, the facility will receive zero (0) points and would only be eligible for the Incentive if they achieve at least 4 points in the other catergories.*

3. Three Quarter points for year over year improvement are only awarded to providers who do not meet the criteria to earn 1-3 points within the measure.
4. Providers must have a quality score of at least the four (4) points to qualify for a quality incentive payment.
5. Participation in the Quality Incentive Add-On is voluntary and a facility has the option to opt out and not participate.
6. The weighted provider score for each qualifying provider is calculated by multiplying the provider quality points by the number of annualized Medicaid days as reported on the most recent June 30 cost report received by the Alabama Medicaid Agency. The payment per quality point is established by dividing the total quality budget by the sum of all weighted provider scores. The per diem quality incentive component is calculated by multiplying a provider's weighted quality score by the payment per quality point.