Table of Contents

State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 15-006 NIRT

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 S3-14-28
Baltimore, Maryland 21244-1850

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

Financial Management Group

NOV 10 2015

Ms. Dawn Stehle
State Medicaid Director
Arkansas Department of Health and Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, Arkansas 72203-1437

RE: TN 15-006

Dear Ms. Stehle:

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 15-006. This amendment will change the methodology for calculating the Upper Payment Limit (UPL) from using only Audited cost reports as of June 30 to using the most recently submitted cost reports as of June 30, if the audited cost report is more than 2 years old as of June 30.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

Based on the information provided by the State, Medicaid State plan amendment 15-006 is approved effective August 1, 2015. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

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: 2015-006	2. STATE ARKANSAS
	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 August 1, 2015	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Section 447.205	7. FEDERAL BUDGET IMPACT: a. FFY 2016 $(5,438,669) b. FFY 2017 $(32,226,879)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Page 9 Attachment 4.19-A, Page 11aaa Attachment 4.19-A, Page 11c Attachment 4.19-A, Page 11d Attachment 4.19-B, Page 1a	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same, Approved 09-06-00, TN 00-09 Same, Approved 11-30-04, TN 04-13 Same, Approved 07-27-01, TN 01-11 Same, Approved 12-17-09, TN 09-10 Same, Approved 12-14-09, TN 09-11

10. SUBJECT OF AMENDMENT:

The Arkansas Title XIX State Plan has been amended to allow data from recently submitted cost reports, if the audited report is more than two years old, to be used for the UPL calculations. This is a requirement of Act 1141 of the 2015 Arkansas General Assembly.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: Division of Medical Services PO Box 1437, Slot S295 Little Rock, AR 72203-1437 Attention: Seth Blomeley
13. TYPED NAME: Dawn Stehle	
14. TITLE: Director, Division of Medical Services	
15. DATE SUBMITTED: October 15, 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: October 15, 2015	18. DATE APPROVED: NOV 10 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: August 1, 2015	20. SIG[redacted]FICIAL:
21. TYPED NAME: Kristin FAN	22. TITLE: Associate Regional Administrator Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

1. Inpatient Hospital Services (Continued)

Non-State Public Hospital Inpatient Adjustment (continued)

3. The base Medicaid per discharge rate shall be subtracted from the adjusted Medicare per discharge rate determined pursuant to step 2.

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

5. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30, for Non-State Public Hospital Adjustment. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

State: Arkansas
Date Received: October 15, 2015
Date Approved: NOV 1 0 2015
Date Effective: August 1, 2015
Transmittal Number: 15-006

1. Inpatient Hospital Services (Continued)

Private Pediatric Hospital Inpatient Adjustment

Effective April 19, 2001, all private pediatric hospitals within the state of Arkansas as previously defined in this section of Attachment 4.19-A shall qualify for a pediatric hospital inpatient rate adjustment. The amount of the adjustment shall be determined annually by Arkansas Medicaid based on available funding. Each qualifying hospital's adjustment amount shall be equal to their pro rata share of the total adjustment based on the hospital's Medicaid discharges for the most recent audited fiscal year. In no case shall the pediatric hospital adjustment be in an amount that results in aggregate Medicaid inpatient payments to all private hospitals (including the private hospital inpatient rate adjustment) that are in excess of the applicable Medicare related upper payment limit specified in 42 C.F.R. 447.272.

Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter. Payment for SFY 2001 shall be prorated proportional to the number of days between April 19, 2001 and June 30, 2001 to the total number of days in SFY 2001.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30.

State: Arkansas
Date Received: October 15, 2015
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1. Inpatient Hospital Services (continued)

Inpatient Hospital Access Payments

Effective for services provided on or after July 1, 2009 all privately operated hospitals within the State of Arkansas except for rehabilitative hospitals and specialty hospitals as defined in Arkansas Code Ann. § 20-77-1901(7)(D) and (E) shall be eligible to receive inpatient hospital access payments. The inpatient hospital access payments are considered supplemental payments and do not replace any currently authorized Medicaid inpatient hospital payments.

1. For each rate year, the state shall determine for each hospital and in total the number of Medicaid inpatient discharges for private hospitals eligible for this supplemental payment.
2. For each rate year, the state shall identify, on the basis of paid inpatient discharge claims adjudicated through the State's MMIS, reimbursement for inpatient hospital services that were delivered by the private hospitals identified in step one.
3. The state shall estimate the amount that would have been paid for the services identified in step two using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.272. Respective Case Mix Indexes (CMI) shall be applied to both the base Medicare per discharge rates and base Medicaid per discharge rates for comparison to the Medicare-related UPL.
4. The maximum allowable aggregate Medicaid inpatient hospital access payment for private hospitals shall not exceed 97% of the difference between the results of step three (Medicare UPL) and results of step two (Medicaid based payment).
5. Using discharge data identified in step one, the state shall determine each eligible hospital's pro rata percentage which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges for all eligible hospitals. This percentage will be calculated annually.
6. Each eligible hospital's inpatient hospital access payment shall be determined by multiplying the aggregate inpatient access payment identified in step 4 by the pro rata percentage identified in step 5. The current year's adjustment will be based on discharge data from the most recently audited fiscal year for which there is complete data. In this manner, the State will make supplemental payment to eligible hospitals for current year Medicaid utilization.

Inpatient hospital access payments shall be paid on a quarterly basis.

For hospitals that, for the most recently audited cost report period filed a partial year cost report, such partial year cost report data shall be annualized to determine their inpatient access payment; provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report period shall receive pro-rated adjustments based on the partial year data.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30 for Inpatient Hospital Access Payments. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

State: Arkansas
Date Received: October 15, 2015
Date Approved NOV 1 0 2015
Date Effective: August 1, 2015
Transmittal Number: 15-006

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: August 1, 2015

2.a. Outpatient Hospital Services (continued)

Outpatient Hospital Access Payments

Effective for services provided on or after July 1, 2009, all privately operated hospitals within the State of Arkansas except for rehabilitative hospitals and specialty hospitals as defined in Arkansas Code Ann. § 20-77-1901 (7) (D) and (E) shall be eligible to receive outpatient hospital access payments. The outpatient hospital access payments are considered supplemental payments and do not replace any currently authorized Medicaid outpatient hospital payments. The outpatient hospital access payments shall be determined on the basis of cost and calculated as follows:

1. For each rate year the state shall identify, on the basis of paid claims adjudicated through the State's MMIS, reimbursement for outpatient hospital services that were delivered by the private hospitals eligible for this supplemental payment.
2. The state shall estimate the amount of cost for the same dates of service identified in step one using Medicare cost principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321. The State will utilize cost data in a manner approved by CMS.
3. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals shall not exceed the difference between the results of step one (Medicaid based payment) and results of step two (Medicaid outpatient hospital services cost).
4. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals identified in step three shall be divided by the total Medicaid outpatient hospital services base payment for eligible hospitals identified in step one to arrive at an adjustment percentage. This percentage will be calculated annually.
5. Each eligible hospital's outpatient hospital access payment shall be determined by multiplying the Medicaid outpatient hospital services payment identified in step one by the adjustment factor determined in step four. The current year's adjustment will be based on cost data from the most recently audited fiscal year for which there is complete data. In this manner, the State will make supplemental payment to eligible hospitals for current year Medicaid utilization.

Outpatient hospital access payments shall be paid on a quarterly basis.

For hospitals that, for the most recently audited cost report period filed a partial year cost report, such partial year cost report data shall be annualized to determine their outpatient access payment; provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report period shall receive pro-rated adjustments based on the partial year data.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30 for Outpatient Hospital Access Payments. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

(2) Pediatric Hospitals

Effective for claims with dates of service on or after April 1, 1992, outpatient hospital facility services provided at a pediatric hospital will be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. The State will utilize cost data in a manner approved by CMS consistent with the method used for identifying cost for the private hospital access payments.

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost settlements. Except for graduate medical education costs, the cost settlements will be calculated using the methods and standards used by the Medicare Program. Graduate medical education costs are reimbursed based on Medicare cost rules in effect prior to the September 29, 1989, rule change.

State: Arkansas
Date Received: October 15, 2015
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Transmittal Number: 15-006

1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals (Continued)

(d) Physicians/Administrative/Teachers will be included in costs as recognized by Medicare HIM-15 reimbursement principles.

(e) Arkansas State Operated Teaching Hospital Adjustment: Effective May 9, 2000, Arkansas State Operated Teaching Hospitals shall qualify for an inpatient rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit. The adjustment shall be calculated as follows:

1. Using the most current audited data, Arkansas shall determine each State Operated Teaching Hospital's base Medicare per discharge rate and base Medicaid per discharge rate.
2. The base per discharge rates shall be trended forward to the current fiscal year using an annual Consumer Price Index inflation factor.
3. Once the per discharge rates have been trended forward, the Medicare per discharge rate will be divided by the Medicare case mix index and the Medicaid per discharge rate will be divided by the Medicaid case mix index. The Medicare case mix index reflects the hospital's average diagnosis related group (DRG) weight for Medicare patients. The Medicaid case mix index reflects the hospital's average DRG weight for Medicaid patients using the Medicare DRGs.
4. The base Medicaid per discharge rate shall be subtracted from the base Medicare per discharge rate.
5. The difference shall be multiplied by the hospital's Medicaid case mix index.
6. The adjusted difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent fiscal year. The result shall be the amount of the annual State Operated Teaching Hospital Adjustment.
7. Payment shall be made on an annual basis before the end of the state fiscal year.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30.

Any costs associated with heart, liver, non-experimental bone marrow, lung and skin transplants will not be reimbursed through a cost settlement. Refer to Attachment 4.19-A, Page 3, for the reimbursement methodology for these procedures.

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