EXHIBIT L

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: Hospital 5-15 and State Plan Amendment #2014-009; Consolidate Private Hospital UPLs

DESCRIPTION: Arkansas will remove the annual Private Hospital Inpatient Adjustments UPL from the state plan and increase the inpatient hospital access payments.

PUBLIC COMMENT: No public hearing was held on this rule. The Public Comment period expired on September 15, 2015. The Department did not receive any public comments.

The proposed effective date is November 1, 2015.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact. The result of this rule change is that the Private Hospital Inpatient Adjustment Upper Payment Limit (UPL) will now be paid through the Inpatient Hospital Access Payment UPL. The hospitals pay the match for the Inpatient Hospital Access Payment UPL through the assessment fee. This change does not have an impact on state general revenue.

LEGAL AUTHORIZATION:

Ark. Code Ann. § 20-76-201 authorizes the Department of Human Services to administer programs for the indigent and to "make rules and regulations" pertaining to the administration of those programs.

EXHIBIT L

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Dawn Stehle

CONTACT PERSON Brian Jones

ADDRESS PO Box 1437, Slot S295, Little Rock, AR 72203

PHONE NO. 501-537-2064 **FAX NO.** 404-4619 **E-MAIL** Brian.Jones@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Tami Harlan

PRESENTER E-MAIL tami.harlan@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? Hospital 5-15 and State Plan Amendment #2014-009 - To consolidate Private hospital UPL's

2. What is the subject of the proposed rule? Arkansas will remove the annual Private Hospital Inpatient Adjustment UPL from the state plan and increase the Inpatient Hospital Access Payments.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒

If yes, please provide the federal rule, regulation, and/or statute citation. _____

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

If yes, what is the effective date of the emergency rule? _____

When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒

If yes, please provide a brief summary explaining the regulation.

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: This rule removes the annual Private Hospital Inpatient Adjustment UPL from the Arkansas State Plan.**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? The purpose of the proposed rule is to remove the Private Hospital UPL.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☐ No ☒

If yes, please complete the following:

Date: _____

Time: _____

Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

September 15, 2015

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

November 1, 2015 (Adopted by Federal Regulation October 1, 2014)

12. Do you expect this rule to be controversial? Yes ☐ No ☒
If yes, please explain. _____

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE NO. 501-537-2064 **FAX NO.** 501-404-4619 **EMAIL:** Brian.jones@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Hospital 5-15 and SPA #2014-009 To consolidate Private hospital UPL's

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$0	Total	$0

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year
$	$

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	Next Fiscal Year
$ $0	$ $0

The result of this rule change is that the Private Hospital Inpatient Adjustment Upper Payment Limit (UPL) will now be paid through the Inpatient Hospital Access Payment UPL. The hospitals pay the match for the Inpatient Hospital Access Payment UPL through the assessment fee. This change does not have an impact on State General Revenue.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
    (a) justifies the agency's need for the proposed rule; and
    (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
    (a) the rule is achieving the statutory objectives;
    (b) the benefits of the rule continue to justify its costs; and
    (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

1. Inpatient Hospital Services (Continued)

Limited Acute Care Hospital Inpatient Quality Incentive Payment

Effective for claims with dates of service on or after January 1, 2007, all acute care hospitals with the exception of Pediatric Hospitals, Border City University-Affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals, Rehabilitative Hospitals, Inpatient Psychiatric Hospitals, Critical Access Hospitals, and Out-of-State Hospitals may qualify for an Inpatient Quality Incentive Payment. The Inpatient Quality Incentive Payment shall be a per diem amount reimbursed in addition to the hospital's cost-based interim per diem rate and shall be payable for beneficiaries ages 1 and above only (does not include children hospitalized on their first birthday). The Inpatient Quality Incentive Payment shall equal $50 or 5.9% of the interim per diem rate, whichever is lower. The Inpatient Quality Incentive Payment reimbursement amounts shall not be included when calculating hospital year-end cost settlements.

The State Agency will determine which quality measures will be designated for the Inpatient Quality Incentive Payment for the upcoming year and the required compliance rate for each measure. The State Agency will utilize quality measures which are reported by hospitals under the Medicare program. In order to qualify for an Inpatient Quality Incentive Payment, a hospital must meet or exceed the compliance rate on two-thirds of the designated quality measures designated by the State Agency for the most recently completed reporting period. A hospital that meets or exceeds the compliance rate on two-thirds of the designated quality measures shall receive an Inpatient Quality Incentive Payment for that year.

State: Arkansas
Date Received: October 21, 2014
Date Approved: DEC 05 2014
Date Effective: October 1, 2014
Transmittal Number: 14-009
Supersedes TN# 08-15

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, **the aggregate** reimbursement **amount** for inpatient hospital services that were delivered by the private hospitals identified in step one. **Such aggregate amount shall include all other Medicaid inpatient reimbursement to private hospitals eligible for this adjustment and all Medicaid inpatient reimbursement to private hospitals not eligible for this adjustment and shall include all Inpatient Quality Incentive Payments, but shall not include the amount of the pediatric inpatient payment adjustment.**
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 **upper payment limit. These case mix adjustments are necessary in order to neutralize the impact of the differential between Medicare and Medicaid patients.**
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 maximum allowable 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.

State: Arkansas
Date Received: October 21, 2014
Date Approved: DEC 05 2014
Date Effective: October 1, 2014
Transmittal Number: 14-009
Supersedes TN# 09-10

Mark up

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: ~~January 1, 2008~~October 1, 2014

1. Inpatient Hospital Services (Continued)

Limited Acute Care Hospital Inpatient Quality Incentive Payment

Effective for claims with dates of service on or after January 1, 2007, all acute care hospitals with the exception of Pediatric Hospitals, Border City University-Affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals, Rehabilitative Hospitals, Inpatient Psychiatric Hospitals, Critical Access Hospitals, and Out-of-State Hospitals may qualify for an Inpatient Quality Incentive Payment. The Inpatient Quality Incentive Payment shall be a per diem amount reimbursed in addition to the hospital's cost-based interim per diem rate and shall be payable for beneficiaries ages 1 and above only (does not include children hospitalized on their first birthday). The Inpatient Quality Incentive Payment shall equal $50 or 5.9% of the interim per diem rate, whichever is lower. The Inpatient Quality Incentive Payment reimbursement amounts shall not be included when calculating hospital year-end cost settlements.

The State Agency will determine which quality measures will be designated for the Inpatient Quality Incentive Payment for the upcoming year and the required compliance rate for each measure. The State Agency will utilize quality measures which are reported by hospitals under the Medicare program. In order to qualify for an Inpatient Quality Incentive Payment, a hospital must meet or exceed the compliance rate on two-thirds of the designated quality measures designated by the State Agency for the most recently completed reporting period. A hospital that meets or exceeds the compliance rate on two-thirds of the designated quality measures shall receive an Inpatient Quality Incentive Payment for that year.

~~Private Hospital Inpatient Adjustment~~

~~Effective April 19, 2001, all Arkansas private acute care and critical access hospitals (that is, all acute care and critical access hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private pediatric hospitals, shall qualify for a private hospital inpatient rate adjustment. Effective August 1, 2002, all Arkansas private inpatient psychiatric and rehabilitative hospitals (that is, all inpatient psychiatric and rehabilitative hospitals within the state of Arkansas that are neither owned nor operated by state or local government) shall qualify for a private hospital inpatient rate adjustment. The adjustment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid discharges. The adjustment shall be calculated as follows:~~

~~1. The amount of the funding pool shall be $24,200,000 for State Fiscal Year (SFY) 2007, $25,200,000 for SFY 2008 and $25,200,000 for all following SFYs.~~

~~2. For each private hospital eligible for the adjustment, Arkansas shall determine the number of Medicaid discharges for the hospital for the most recent audited fiscal year.~~

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: ~~July 1, 2006~~October 1, 2014

~~1. Inpatient Hospital Services (Continued)~~

~~Private Hospital Inpatient Adjustment (continued)~~

~~For private inpatient psychiatric and rehabilitative hospitals for the SFY 2003 adjustment, discharges will be included as prorated proportional to the August 1, 2002 effective date.~~

~~3. For each eligible private hospital, Arkansas shall determine its pro rata percentage which shall be a fraction equal to the number of the hospital=s Medicaid discharges determined pursuant to step 2 divided by the total number of Medicaid discharges for all eligible hospitals.~~

~~4. The amount of each eligible hospital=s payment adjustment shall be its pro rata percentage multiplied by the amount of available funding for the private hospital adjustment pool determined pursuant to step 1.~~

~~Arkansas shall determine the aggregate amount of Medicaid inpatient reimbursement to private hospitals. Such aggregate amount shall include all private hospital payment adjustments, other Medicaid inpatient reimbursement to private hospitals eligible for this adjustment and all Medicaid inpatient reimbursement to private hospitals not eligible for this adjustment **and shall include all Inpatient Quality Incentive Payments,** but shall not include the amount of the pediatric inpatient payment adjustment. Such aggregate amount shall be compared to the Medicare related upper payment limit for private hospitals specified in 42 C.F.R. ›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 upper payment limit. These case mix adjustments are necessary in order to neutralize the impact of the differential between Medicare and Medicaid patients. To the extent that this private hospital adjustment results in payments in excess of the upper payment limit, such adjustments shall be reduced on a pro rata basis according to each hospital=s Medicaid discharges. Such reduction shall be no more than the amount necessary to ensure that aggregate Medicaid inpatient reimbursement to private hospitals is equal to but not in excess of the upper payment limit.~~

5. ~~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.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: ~~July 1, 2009~~October 1, 2014

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, the aggregate reimbursement amount for inpatient hospital services that were delivered by the private hospitals identified in step one. Such aggregate amount shall include all other Medicaid inpatient reimbursement to private hospitals eligible for this adjustment and all Medicaid inpatient reimbursement to private hospitals not eligible for this adjustment and shall include all Inpatient Quality Incentive Payments, but shall not include the amount of the pediatric inpatient payment adjustment.
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~~ upper payment limit. ~~in the same manner as is approved by CMS and described in the Private Hospital Inpatient Adjustment section of this Attachment~~ These case mix adjustments are necessary in order to neutralize the impact of the differential between Medicare and Medicaid patients.
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 maximum allowable 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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)

DATE: October 1, 2014

SUBJECT: Provider Manual Update Transmittal HOSPITAL-5-15

PROPOSED

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
250.300	10-13-03	250.300	10-1-14

Explanation of Updates

Section 250.300 has been updated to announce the removal of the annual "Private Hospital Inpatient Adjustment" UPL $25.2 million methodology payments.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

TOC not required

250.623 Private Hospital Inpatient Adjustment 10-1-14

Effective October 1, 2014, Arkansas Medicaid will remove the annual "Private Hospital Inpatient Adjustment" UPL $25.2 million methodology payments. The last quarterly "Private Hospital Inpatient Adjustment" reimbursement payments will be made within 15 days after September 30, 2014 for that quarter ending data.

/Mark 4/

TOC not required

250.623 Private Hospital Inpatient Adjustment ~~1110~~-15-~~1214~~

Effective October 1, 2014, Arkansas Medicaid will remove the annual "Private Hospital Inpatient Adjustment" UPL $25.2 million methodology payments. The last quarterly "Private Hospital Inpatient Adjustment" reimbursement payments will be made within 15 days after September 30, 2014 for that quarter ending data.

~~All Arkansas private acute care and critical access hospitals (that is, all acute care and critical access hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private pediatric hospitals, qualify for a private hospital inpatient rate adjustment.~~

~~All Arkansas private inpatient psychiatric and rehabilitative hospitals (that is, all inpatient psychiatric and rehabilitative hospitals within the state of Arkansas that are neither owned nor operated by state or local government) shall also qualify for a private hospital inpatient rate adjustment.~~

~~The adjustment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid discharges. The amount of the funding pool shall be determined annually by Arkansas Medicaid, based on available funding. The adjustment shall be calculated as follows:~~

~~A. Arkansas Medicaid shall annually reimburse $25.2 million for the private hospital adjustment funding pool.~~

~~B. For each private hospital eligible for the adjustment, Arkansas Medicaid shall determine the number of Medicaid discharges for the hospital for the most recent audited fiscal period.~~

~~1. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.~~

~~2. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.~~

~~3. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1st of the state fiscal year (SFY) for which the adjustment payments will be made.~~

~~4. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.~~

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

~~For private inpatient psychiatric and rehabilitative hospitals for the SFY 2003 adjustment, discharges will be included as pro-rated proportional to the August 1, 2002, effective date.~~

~~C. For each eligible private hospital, Arkansas Medicaid shall determine its 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 of all eligible hospitals.~~

~~D. The amount of each eligible hospital's payment adjustment shall be its pro rata percentage multiplied by the amount of available funding for the private hospital adjustment pool determined by Arkansas Medicaid.~~

~~Arkansas shall determine the aggregate amount of Medicaid inpatient reimbursement to private hospitals. Such aggregate amount shall include all private hospital payment~~

~~adjustments, other Medicaid inpatient reimbursement to private hospitals eligible for this adjustment and all Medicaid inpatient reimbursement to private hospitals not eligible for this adjustment; but this shall not include the amount of the pediatric inpatient payment adjustment. Such aggregate amount shall be compared to the Medicare-related upper payment limit for private hospitals specified in 42 C.F.R. 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 upper payment limit. These case mix adjustments are necessary in order to neutralize the impact of the differential between Medicare and Medicaid patients.~~

~~To the extent that this private hospital adjustment results in payments in excess of the upper payment limit, such adjustments shall be reduced on a pro rata basis according to each hospital's Medicaid discharges. Such reduction shall be no more than the amount necessary to ensure that aggregate Medicaid inpatient reimbursement to private hospitals is equal to but not in excess of the upper payment limit.~~

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