



Arkansas Department of Human Services

Division of Medical Services

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OFFICIAL NOTICE

DMS-2001-L-5

TO: Health Care Provider – Hospital

DATE:

SUBJECT: Critical Access Hospitals

I. Introduction

The Arkansas Medicaid Program will enroll qualified acute care hospitals that have been certified by the Secretary of the Department of Health and Human Services and licensed as Critical Access Hospitals (CAHs), in the Arkansas Medicaid Critical Access Hospital Program, effective for dates of service on and after August 1, 2001.

- A. Critical Access Hospitals that are currently licensed by the Arkansas Department of Health (ADH) as CAHs and currently enrolled in the Arkansas Medicaid Hospital Program must enroll in the Critical Access Hospital Program.
- B. Hospitals not currently licensed by ADH as Critical Access Hospitals but which later change their ADH licensure to CAH must apply for Medicaid Critical Access Hospital Program enrollment at the time of the licensure change.

II. Conditions of Participation

- A. Only hospitals licensed as CAHs by the Arkansas Department of Health (ADH) may enroll in the Arkansas Medicaid Critical Access Hospital Program.
 - 1. A copy of the current license must accompany the Medicaid application and contract.
 - 2. Enrolled hospitals must submit proof of subsequent licensure or license renewal when issued.
- B. To be eligible for participation in the Arkansas Medicaid Critical Access Hospital Program a hospital must have Title XVIII (Medicare) certification as a Critical Access Hospital.
 - 1. A copy of the current Medicare certification must accompany the Medicaid application and contract.
 - 2. Enrolled hospitals must submit proof of subsequent certification or certification renewal when issued.
- C. To enroll in the Arkansas Medicaid Critical Access Hospital Program, a hospital must complete an application and contract with the Arkansas Medicaid Program.
 - 1. The Arkansas Medicaid enrollment application and the provider contract, with instructions, are located in Section I of any Arkansas Medicaid provider manual.
 - 2. You may copy the pages from the manual or you may call Provider Enrollment at 501-682-8323, to have an enrollment packet mailed to you.
- D. Upon approval of the application and contract, the Arkansas Medicaid Program will establish the effective date of the enrollment and assign a provider number, forwarding to the provider a letter of confirmation of these items.

III. Coverage

A. Scope of Coverage

Arkansas Medicaid covers medically necessary inpatient and outpatient hospital services that are permitted under the Critical Access Hospitals' licensures, to the extent that the same services are covered under the Arkansas Medicaid Hospital Program.

B. Coverage Restrictions

Coverage restrictions in the Arkansas Medicaid Hospital Program, *e.g.* restrictions regarding observation beds, also apply in the Arkansas Medicaid Critical Access Hospital Program unless Arkansas Medicaid issues policy guidelines specifically stating otherwise.

1. Arkansas Department of Health regulations stipulate that Critical Access Hospitals may provide medically necessary acute inpatient care for a period not to exceed ninety-six (96) hours, unless:
 - a. A longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions or
 - b. A peer review organization or equivalent entity, upon request, waives the ninety-six (96) hour restriction on a case-by-case basis.
2. The Arkansas Medicaid Program has contracted with Arkansas Foundation for Medical Care, Inc. (AFMC) to determine and certify lengths of stay in the Medicaid Utilization Management Program (MUMP).
 - a. CAHs shall contact AFMC and follow MUMP procedures to certify stays longer than 4 days.
 - b. CAHs receiving inpatients by transfer from a hospital or another CAH must obtain AFMC certification of inpatient stays of any length.
 - c. In addition to MUMP criteria of medical necessity, AFMC will, when applicable, review the CAH's justification for retaining a patient instead of transferring the patient to a hospital.
 - 1) AFMC may retrospectively review inpatient stays of any length for medical necessity.
 - 2) AFMC may retrospectively review inpatient stays of any length for justification for retaining a patient instead of transferring the patient to a hospital.

3. Medicaid recipients under age one (1) at the time of admission are exempt from the 96-hour inpatient stay limitation and the MUMP policy for dates of service before their first birthday.
4. A CAH may provide medically necessary acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient.
 - a. Discharges and average stays are identified and calculated by the Medicare fiscal intermediary and are the same as are used for Medicare purposes.
 - b. The CAH's average length of stay will be reported to the HCFA regional office by the Medicare fiscal intermediary.
 - 1) If a CAH exceeds the average length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the HCFA regional office.
 - 2) If the CAH fails to implement the corrective action plan, the CAH will be subject to termination of its Medicaid provider agreement and other sanctions established under Title XVIII of the Social Security Act.

C. Exclusions

1. Services excluded from coverage in the Arkansas Medicaid Hospital Program are also excluded from the Arkansas Medicaid Critical Access Hospital Program, unless stated otherwise in official Program documentation or correspondence.
2. Medicaid does not cover nursing facility beds ("swing-beds") in hospitals or in CAHs.

IV. Benefit Limits

- A. Inpatient stays, non-emergency outpatient visits and laboratory, radiology and diagnostic machine test coverage in CAHs are subject to the same benefit limits that apply to facilities enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program.
- B. Benefit-limited services received in CAHs are counted with benefit-limited services received in hospitals enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program to calculate a Medicaid-eligible individual's benefit status.

V. Reimbursement

A. Inpatient Reimbursement

1. CAH inpatient reimbursement is by interim per diem rates with year-end cost settlement.
 - a. Allowable costs and cost settlements are determined in accordance with Title XVIII (Medicare) CAH cost principles and applicable cost settlement procedures and calculations.
 - b. A CAH's initial interim per diem rate will be the most recent interim per diem rate it received under its prior enrollment in the Arkansas Medicaid Hospital Program; or the interim per diem calculated from the most recent full year's cost report it submitted under its prior enrollment in the Arkansas Medicaid Hospital Program.
 - c. In the event that a hospital enrolled in the Arkansas Medicaid Hospital Program converts to a CAH before it has had an interim per diem rate in effect for a full cost reporting period, the State will set the facility's CAH interim per diem rate at the mathematical mean of established CAHs' per diem rates in effect on the date Medicaid establishes as the facility's date of enrollment in the Arkansas Medicaid Critical Access Hospital Program.
 - d. A hospital that converts to a CAH, and whose effective date of Medicaid enrollment as a CAH is a date other than the day following the last day of the facility's established cost reporting period under its enrollment in the Arkansas Medicaid Hospital Program, must submit partial-year cost reports under each program in which it maintained enrollment during the cost reporting period.
2. Interim per diem rates are calculated annually in the same manner as are the interim per diem rates of hospitals enrolled in the Arkansas Medicaid Hospital Program.

B. Outpatient Reimbursement

1. CAH outpatient reimbursement consists of interim fee-for-service payment in accordance with the Arkansas Medicaid Program outpatient hospital fee schedule (at the lesser of the billed charge or the fee schedule maximum) with year-end cost settlements.
2. Allowable costs and cost settlements are determined in accordance with Title XVIII (Medicare) CAH cost principles and applicable cost settlement procedures and calculations.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-1461 (voice) or at (501) 682-6789 and 1-877-708-8191 (TDD).

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

Thank you for your participation in the Arkansas Medicaid Program.

Ray Hanley, Director

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