ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Provider Reimbursement
P.O. Box 1437, Slot S-401 · Little Rock, AR 72203-1437
501-682-8292 · Fax: 501-682-1197 · TDD: 501-682-6789

MEMORANDUM

TO: (X) Nursing Facilities; (X) ICFs/MR 16 Bed & Over; (X) HDCs; (X)ICFs/MR Under 16 Beds; ( ) RCFs; (X) Interested Parties; ( ) Hospitals & Discharge Planners; (X) DHS County Offices

FROM: Roy Jeffus, Director, Division of Medical Services

DATE: July 30, 2008

SUBJ: Clarification of Provisional Rate Policy

As a part of the Administrative Procedures Act process, attached is the **proposed** Medicaid policy revision. This proposed rule is effective October 1, 2008. This rule is contingent upon CMS approval.

The public notice of this rule change is scheduled to be published in the July 30, 2008 through August 1, 2008, Arkansas Democrat/Gazette. If you have any comments, please submit those comments in writing, to the following address, no later than August 28, 2008.

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Little Rock, AR 72203-1437

The Division of Medical Services anticipates filing with the Arkansas Legislative Council on July 30, 2008, and the Secretary of State, the Arkansas State Library and the Bureau of Legislative Research on September 5, 2008.

If you have any questions concerning the attached material, please contact Randy Helms at (501) 682-1857.

If you need this material in an alternative format such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-8307 (voice), 682-6789 (TDD), or 1-877-708-8191.

1-3 Activities Not Related to Resident Care

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

1-4 Accrual and Cash Basis of Accounting

For non-governmental providers, the Financial and Statistical Report must be filed using information stated on the accrual method of accounting. The Chart of Accounts is designed to be used in a complete accrual accounting system.

Financial information stated on an accrual basis is essential to insure that the proper reimbursement is made to providers. The measurement of the cost of services performed must include all supplies, salaries, services and other expenses incurred, regardless of whether or not those items have been paid.

Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads. Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system. Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

1-5 Chart of Accounts

The applicable Chart of Accounts shall be used by all Long Term Care Facilities participating in the Title XIX Program. Each Chart of Accounts provides for the basic classifications of all assets, liabilities, income and expense necessary for the preparation of the Cost Report. Providers may take some latitude in assigning account numbers but must maintain the basic Chart of Accounts.

1-6 Cost Reporting Requirements

All providers in operation under a valid Medicaid agreement for long term care services must file a Financial and Statistical Report (commonly referred to as a Cost Report or FSR). In addition to the annual reporting requirement nursing facilities will be required to submit a limited cost report containing direct care cost information for the period January 12, 2001 to June 30, 2001, in order that the direct care per diem can be rebased after this initial period. Nursing facilities that have been newly constructed, newly purchased, or newly leased, or a newly enrolled provider that did not previously participate in Medicaid, will be required to prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. This report is essential in establishing rates for a new provider. If the facility was not certified for Medicaid participation at date of first

calculated from cost reports submitted for the period July 1, 1999 to June 30, 2000. No initial interim rate is necessary because the methodology has been implemented the second half of the rate period and therefore actual rates have been calculated.) The interim rate is necessary to allow time for providers to complete cost reports and allow the Department adequate time to review the cost reports and calculate rates. After the actual per diem calculations occur providers will be paid a weighted per diem rate for the portion of the rate year remaining. The weighted per diem rate will provide for an average payment approximating providers actual per diem.

The following formula will be used to calculate the weighted per diem rate.
{(Actual Per Diem Rate x 12) - (Interim Rate x Months Used)}/ Months Remaining.

3. Provisional Rate

A provisional rate will be paid to a provider who:
A. Constructs a new facility; or
B. Affects a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program. If it is determined that a related party relationship exists between the buyer and seller or lessee and lessor, and the provider (facility) is currently receiving a provisional rate or has received a provisional rate in the previous 24 months, then no additional provisional rate shall be paid and the provider will continue to be paid a rate as if the purchase or lease had not occurred. In such instance, the buyer or lessee shall submit all cost reports required by these regulations as if the purchase or lease had not occurred. If the buyer and/or the seller, or lessee and/or lessor consist of an entity, such as a corporation, company, limited liability company, partnership, association, then the related party criteria set forth herein shall apply to each such entity and its principals, shareholders, partners, etc. A related party relationship exists when there is common ownership of five percent (5%) or more in both the buyer and seller or lessee and lessor; or
C. Enrolls as a Medicaid provider and has not previously participated in the Medicaid program.

The provisional rate will be established as follows.
A. The Direct Care per diem rate will be established at the inflation adjusted ceiling for that rate period.
B. The Indirect, Administrative, and Operating per diem will be the class rate as established for that rate period.
C. The Fair Market Rental Payment will consist of a return on equity payment assuming no debt, a facility rental factor, and property taxes and insurance at the industry average. The industry average for property taxes and insurance will be calculated by dividing the total

cost for all full year facilities as identified on facility cost reports by total resident days for the cost reporting period. The per diem payment will be calculated by dividing the sum of the components above by the required minimum occupancy. New facilities that have been constructed will use an occupancy rate of fifty percent when calculating the per diem for this component. Facilities that want to establish their provisional rate assuming a higher percent of occupancy can do so by supplying projected occupancy figures to the Department. Facilities have the option of providing documents indicating the actual cost of property taxes and insurance to be used for cost of ownership figures. Actual cost of ownership information can be supplied any time during the initial six-month period. The Division will adjust the facility's provisional rate prospectively based on the information provided.

Facilities who are placed on a provisional rate as detailed above must submit a six month cost report as required in section 1-6 of this manual. The provisional rate will be retroactively adjusted to the per diem calculated in the following manner.

A. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.

B. The Indirect, Administrative, and Operating per diem will continue to be the class rate as established in the provisional rate.

C. The amount identified as the sum of the components used in the original calculation (as adjusted for actual cost data if applicable) for the Fair Market Rental Payment will remain as established in the provisional rate. The actual per diem amount will be adjusted to reflect the greater of actual occupancy, or the minimum required occupancy for facilities that have changed ownership or fifty percent occupancy for new facilities. After the initial six-month reporting period the Fair Market Rental payment will be calculated using a minimum occupancy factor as required in 2-4 A.1. C., for both new facilities and facilities that have changed ownership.

If either the provisional rate or the actual rate calculated from the six month cost report extend from one rate period to another, appropriate adjustments will be made to the vendor payment. The inflation index will be applied to the direct care per diem. The administrative and operating per diem will be changed to the class rate for the latest rate period. The fair market rental per diem will be adjusted to reflect any change in the PBV for the latest rate period.

4. Terminating Facilities

   Facilities that withdraw from the Medicaid program either voluntarily or involuntarily will not be required to submit a final cost report. All payments made to a facility as interim or provisional will be considered as final. This provision does not apply to any fines or penalties that have been imposed on a facility. This provision does not apply to the sale or lease of a facility between related parties with common ownership as defined in section 2-4 A. 3 above.

5. Inflation Index

   For all inflation adjustments (unless stated otherwise in the specific area of the plan) the Department will use the Skilled Nursing Facility Market Basket – Without Capital index published by Standard & Poor's DRI published for the quarter ending June 30th of the cost reporting period. The Department will use the %MOVAVG figure identified for the final quarter of the rate period.

6. Adjustments to Provider Cost Reports

   Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review, or audit. Should a provider's per diem be adjusted for any reason a retroactive adjustment will be made for all resident days paid back to the beginning of the rate period. Adjustments to a provider's per diem resulting from any source other than