ADMINISTRATIVE PROCEDURES
PROVIDER FEE FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

DEFINITIONS

A. *"Director"* means the director of the division;

B. *"Division"* means the Division of Medical Services of the Department of Human Services;

C. *"Medicaid"* means the Medical Assistance Program established by Title XIX of the Social Security Act, 42 U.S.C § 1396 et seq., as it existed on January 1, 2009, and administered by the Division;

D. *"Gross Receipts"* means all compensation paid to intermediate care facilities for individuals with developmental disabilities for services provided to residents including, without limitation, client participation. Gross receipts does not include charitable contributions;

E. *"Intermediate care facility for individuals with developmental disabilities"* (hereafter referred to as "Facility" or "Facilities") means a residential institution maintained for the care and training of persons with developmental disabilities, including without limitation mental retardation;

"Intermediate care facility for individuals with developmental disabilities" has the same meaning as "intermediate care facility for the mentally retarded" or "ICF/MR" under federal law;

"Intermediate care facility for individuals with developmental disabilities" does not include:

(i) Offices of private physicians and surgeons;
(ii) Residential care facilities;
(iii) Assisted living facilities;
(iv) Hospitals;
(v) Institutions operated by the federal government;
(vi) Life care facilities;
(vii) Nursing facilities; or
(viii) A facility which is conducted by and for those who rely exclusively upon treatment by prayer for healing in accordance with tenets or practices of a recognized religious denomination;

F. *"Midnight census"* means the count of:

(i) Each patient occupying a facility bed at midnight of each day;
(ii) Those beds placed on hold during a period of time not to exceed five consecutive calendar days during which a patient is in a hospital bed; and

(iii) Those beds placed on hold during a period of time not to exceed fourteen (14) consecutive calendar days during which a patient is on therapeutic home leave;

G. "*Patient days*" means the number of patients in a facility as determined by the midnight census.

H. *"Accounts Receivable"* means the Accounts Receivable unit of the Office of Finance and Administration of the Department of Human Services.

I. *"Multiplier"* means the fixed dollar amount used to calculate the Provider Fee.

PROVIDER REVENUES

Aggregate gross receipts used for the purpose of calculating the multiplier will be projected for each annual period. Gross receipts will be projected for each Facility by multiplying projected patient days by their projected per diem rate. Gross receipts by Facility will be added together to derive aggregate gross receipts.

MIDNIGHT CENSUS DATA

All Facilities shall report their patient days on a monthly basis on a form prescribed by the Division of Medical Services for the specific purpose of reporting patient days.

FEE ASSESSMENT, BILLING, COLLECTION

Each Facility shall file a report with the Department of Human Services by the 10th of each month for the preceding month, listing the patient days per midnight census as required by regulations promulgated by the Division of Medical Services.

Accounts Receivable will calculate the Provider Fee by multiplying patient days as reported by the Facilities for the previous month by the multiplier for that date of service. Billing will be sent no later than the 15th of each month. A copy of the Patient Census Report and statement will be forwarded to Division of Medical Services.

The fee shall then be due and payable for the previous month by the 30th of the month.

From July 31, 2009, to June 30, 2010, the multiplier shall be set at $15.15 per patient day. The multiplier will be recalculated each July 1st in accordance with Act 433 of 2009.

Failure of any Facility to file required reports and/or pay fees on a timely basis may result in the withholding of Medicaid reimbursement, license non-renewal, letters of caution, sanctions and/or fines. The fine shall be at least one thousand dollars ($1,000) but no more than one thousand five hundred dollars ($1,500). The fine and if applicable, the outstanding balance of the provider fee, shall accrue interest at the maximum rate permitted by law from the date the fine and, if applicable, the provider fee, is due until payment of the outstanding balance of the fine and if applicable, the provider fee. Accounts Receivable will initiate the collection process on the 1st of the month following the due date for payments not postmarked by close of business on 30th of the month. Outstanding accounts report will be forwarded to Division of Medical Services for determination of further action.

CHANGE OF OWNERSHIP OR MANAGEMENT

The liability for any amount owed the Division in connection with the Provider Fee is joint and several as between or among the original obligor and any successor licensees.

ADMINISTRATION OF FEES

Fees assessed and collected will be deposited in a designated account within the Arkansas Medicaid Program Trust Fund as established under Arkansas Code Annotated §19-5-985.

SANCTIONS

Sanctions will be assessed by the Division on all Facilities that fail to comply with the provisions of Act 433 of 2009, "An Act To Establish A Provider Fee For Intermediate Care Facilities For Individuals With Developmental Disabilities" (the "Act"), as implemented by these regulations. Any fee or fine imposed under these regulations, as authorized by the Act, shall accrue interest at the maximum rate permitted by law from the date the fee and/or fine is imposed until the Facility pays the fee and/or fine.

For the purposes of this section, "postmarked" shall mean dated for delivery to the Division and submitted to the appropriate carrier by whatever means

designated by the Division including electronic or other means. The procedures for suspension and reinstatement of a license set forth in this section shall only apply to violations of these regulations.

A. Midnight Census Data

Should a Facility fail to submit Midnight Census data to the Division within the time specified in the Act, the following sanctions shall be imposed:

1. If the Midnight Census data is not received within ten (10) days after the date on which the data must be postmarked for transmission to the Division, the Division shall issue a letter of caution to the Facility.

2. If the Midnight Census data is not received within twenty (20) days after the date on which the data must be postmarked for transmission to the Division, the Facility shall be deemed to be in non-compliance with the Act and the Facility shall be fined at least one thousand dollars ($1,000) but no more than one thousand five hundred dollars ($1,500), such amount to be dependent upon the number of times the Facility has been found to be in non-compliance with the Midnight Census data reporting requirement of the Act within the twelve (12) months immediately preceding the date of noncompliance:

   a. First finding of non-compliance: $1,000
   b. Second finding of non-compliance: $1,250
   c. Third finding of non-compliance: $1,500

3. Failure to provide Midnight Census data on four (4) or more occasions within any twelve (12) month period will result in the Division directing the Office of Long Term Care to suspend a Facility's license to operate for a period of not less than thirty (30) days and not more than ninety (90) days, such period to be determined by the Director.

B. Payment of Provider Fee

Should a Facility fail to pay any Provider Fee to the Division, the following sanctions shall be imposed upon that facility.

1. If the Provider Fee is not received within ten (10) days of the date it is due to the Division, the Facility shall be deemed to be in non-compliance with the Act. The Department will assess a fine on any Facility found to be in non-compliance with its obligation to remit this fee to the Division, and the Facility shall be fined at least one thousand dollars ($1,000) but no more than one thousand five hundred dollars ($1,500), such amount to be

dependent upon the number of times the Facility has been found to be in non-compliance with the obligation to remit imposed fees to the Division within the twelve (12) months immediately preceding the date of non-compliance:

a. First finding of non-compliance: $1,000
b. Second finding of non-compliance: $1,250
c. Third finding of non-compliance: $1,500

2. Failure to pay the Provider Fee within the time specified by these regulations on four (4) or more occasions within any twelve (12) month period will result in the Division directing the Office of Long Term Care to suspend a Facility's license to operate for a period of not less than thirty (30) days and not more than ninety (90) days, such period to be determined by the Director.

C. Procedures for Reinstatement of License

Should a license for a Facility be suspended under the terms of these regulations, except for those suspensions provided for in Part E of this section, the license will be reinstated upon full payment of all fines, fees, interest or other charges imposed by the Division, along with a showing, to the Division's satisfaction, that measures are in place to ensure future compliance with the Act.

D. Procedures for Chronic Violations

Any Facility that is in non-compliance on six (6) or more occasion in any twelve (12) month period with any obligation imposed by the Act, as implemented in these regulations, shall be deemed to be a chronic violator of the Act and a threat to the safety of Arkansans in an "Intermediate Care Facility For Individuals With Developmental Disabilities." Any Facility found to a chronic violator of the Act shall have its license suspended by the Office of Long Term Care and such license will be reinstated only after the Facility complies with the Act's requirements, including payment of all applicable fees, fines, interest or other sanction and adopts measures that, to the satisfaction of the Division, will ensure future compliance with the Act. After the adoption of these measures and satisfaction of all sanctions, the license for the Facility. Any subsequent violation of the Act by a Facility within twelve (12) months after its license is reinstated pursuant to the procedures set forth in this part of this section, will result in a suspension of the Facility license by the Office of Long Term Care for a period of not less that ninety (90) days and no more than one hundred eighty (180) days, such duration to be

determined by the Director, and such license shall be reinstated only for good cause shown.

E. Period of Suspension

Any period of suspension of a Facility license to operate under this section shall extend from the end of any appeal made by that facility that is resolved in favor of the Division.

F. Recoupment Provisions

The Division may withhold from a licensee's vendor payment any amount owed the Medicaid program as a result of an imposed fine for non-compliance as detailed in sections A, B, C, above, or any provider fee not paid by the due date. For purposes of this paragraph, a fine is considered imposed once the Division notifies the licensee of the fine and the licensee has an opportunity to appeal the fine.

G. Defenses

In any action taken under this section by the Division to enforce the payment of the provider fee established under Ark. Code Ann. § 20-48-901-904, or to compel the payment of such fees, it shall be a complete defense for a Facility that:

1. The Centers for Medicare and Medicaid Services has not approved the State Medicaid Plan amendment described in Ark. Code Ann. § 20-48-902(b)(2) for the Facility; or

2. Fewer than 45 calendar days have elapsed since the Centers for Medicare and Medicaid Services has approved the State Medicaid Plan amendment described in Ark. Code Ann. § 20-48-902(b)(2) for the Facility.

The Division may re-file any action that is subject to the defense provided in this section at such time as the action is no longer barred.

APPEAL PROCEDURES

Appeal procedures for a Facility are outlined in Section 1-10 of the Department of Human Services Medical Assistance Program Manual of Cost Reimbursement Rules For Long Term Care Facilities. Providers can obtain a copy of these procedures by contacting the Provider Reimbursement Unit at (501) 682-8366.

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REFERENCES

Act 433 of the Regular Session of the 87th General Assembly. Effective July 31, 2009

Department of Human Services Medical Assistance Program Manual of Cost Reimbursement Rules For Long Term Care Facilities.

Arkansas Administrative Procedure Act, Arkansas Code Annotated § 25-15-201, et seq.

Title XIX of the Social Security Act, 42 U.S.C § 1396 et seq.

Arkansas Department of Human Services
Division of Medical Services
Midnight Census Reporting for Provider Fee

Facility Name _____ Vendor Number _____

Month _____ MMIS Provider Number _____

Midnight Census as Defined in the "Administrative Procedures Of Intermediate Care Facilities For Individuals With Developmental Disabilities Provider Fee"

Day of month	Midnight Census	Day of month	Midnight Census
1		17	
2		18	
3		19	
4		20	
5		21	
6		22	
7		23	
8		24	
9		25	
10		26	
11		27	
12		28	
13		29	
14		30	
15		31	
16			

Total of Midnight Census _____