ADMINISTRATIVE PROCEDURES
HOSPITAL ASSESSMENT FEE

DEFINITIONS

(1) "Division" means the Division of Medical Services of the Department of Human Services;

(2) “Hospital” means a health care facility licensed as a hospital by the Division of Health Facility Services of the Department of Health under Ark Code Ann. § 20-9-213;

(3) “Medicare Cost Report” means CMS-2552-96, the Cost Report for Electronic Filing of Hospitals, as it existed on January 1, 2009;

(4) “Audited Medicare Cost Report” means the most recent audited cost report that specifically includes the audited worksheets, calculations and information related to the Arkansas Medicaid Program. 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 assessment purposes. The most current audited cost report period is used when an earlier period’s NPR is finalized after a later period’s. In order to be used to calculate the assessment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1st of the state fiscal year (SFY) for which the assessment will be collected.

(5) “Net patient revenue” means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the Medicare Cost Report adjusted to exclude nonhospital revenue;

(6) “Non-state-government-owned Hospital” means a Hospital in Arkansas that:

(A) Is owned and operated by an agency or a unit of a county or municipal government, including without limitation a hospital owned and operated by:

(i) A county under Ark Code Ann. § 14-263- 101 *et seq.*; or

(ii) A city under Ark Code Ann. § 14-264-101 *et seq.;*

(B) Meets all other Federal requirements describing “non-state-government owned” status determination not already identified in (A).

However, a “Non-state-government-owned-Hospital” does not include a Hospital that is owned by an agency or unit of county or municipal government but is contracted or leased to an individual, firm, or corporation that is not a government entity.

(7) “Privately operated Hospital” means a Hospital in Arkansas other than:

(A) Any hospital that is owned and operated by the federal government;
(B) Any Hospital that is an agency or a unit of state government, including without limitation a Hospital owned by a state agency or a state university;
(C) Any non-state government owned Hospital; and

Private Hospitals must also meet all other Federal requirements describing “privately owned” status determination not already identified in (A), (B) and (C) above.

(8) “Specialty Hospital” means an acute care general Hospital that:

(A) Limits services primarily to children and qualifies as exempt from the Medicare prospective payment system regulation; or
(B) Is primarily or exclusively engaged in the care and treatment of patients with cardiac conditions;

(9) “State plan amendment” means a change or update to the state Medicaid plan;

(10) "Upper payment limit" means the maximum ceiling imposed by federal regulation on privately operated hospital Medicaid reimbursement for inpatient services under 42 C.F.R § 447.272 and outpatient services under 42 C.F.R § 447.321; and

(11) “Upper payment limit gap” means the difference between the upper payment limit and Medicaid payments not financed using Hospital assessments made to all privately operated hospitals.

(A) The upper payment limit gap shall be calculated separately for Hospital inpatient and outpatient services.
(B) Medicaid disproportionate share payments shall be excluded from the calculation of the upper payment limit gap.

(12) “Accounts Receivable” means the Accounts Receivable Unit of the Office of Finance and Administration of the Department of Human Services.

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PROVIDER REVENUES & ASSESSMENT RATE

An assessment is imposed on each Hospital, except those exempted under Ark Code Ann § 20-77-1905, for each state fiscal year in an amount calculated as a percentage of each Hospital's net patient revenue.

The assessment rate is determined annually based upon the percentage of net patient revenue needed to generate an amount up to the non-federal portion of the upper payment limit gap plus the annual fee to be paid to Medicaid under Ark Code Ann. § 20-77-1904(f)(1)(C). In no case is the assessment rate greater than one percent (1%) of net patient revenue.

For state fiscal year 2010, net patient revenue will be determined using the data from each Hospital's fiscal year 2007 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' (CMS) Healthcare Cost Report Information System file dated June 30, 2008, except that:

(A) If a Hospital's fiscal year 2007 Medicare Cost Report is not contained in the CMS Healthcare Cost Report Information System file dated June 30, 2008, the Hospital will submit a copy of the hospital's 2007 Medicare Cost Report to the Division in order to allow the Division to determine the Hospital's net patient revenue for state fiscal year 2010; and

(B) If a Hospital commenced operations after the due date for a 2007 Medicare Cost Report, the Hospital shall submit its 2008 Medicare Cost Report to the Division in order to allow the Division to determine the Hospital's net patient revenue for state fiscal year 2010.

For state fiscal year 2011 and following years, net patient revenue shall be calculated using the data from each Hospital's most recent audited Medicare Cost Report available at the time of the calculation.

FEE ASSESSMENT

The Division will send a notice of assessment to each Hospital informing the Hospital of the assessment rate, the Hospital's net patient revenue calculation, and the estimated assessment amount owed by the Hospital for the applicable fiscal year.

With the exception of the initial notice of assessment, annual notices of assessment will be sent at least forty-five (45) days before the due date for the first quarterly assessment payment of each fiscal year. The first notice of assessment will be sent within forty five (45) days after receipt by the Division of

notification from the Centers for Medicare and Medicaid Services that the payments required under Ark. Code Ann. § 20-77-1908 and, if necessary, the waiver granted under 42 C.F.R. § 433.68 have been approved. The Hospital will have thirty days from the date of its receipt of a notice of assessment to review and verify the assessment rate, the Hospital's net patient revenue calculation, and the estimated assessment amount.

If a Hospital provider operates, conducts, or maintains more than one (1) Hospital in the state, the Hospital provider will pay the assessment for each Hospital separately. However, if the Hospital provider operates more than one (1) Hospital under one (1) Medicaid provider number, the Hospital provider may pay the assessment for all such Hospitals in the aggregate.

For a Hospital subject to the assessment imposed under Ark. Code Ann. § 20-77-1902 that ceases to conduct hospital operations or maintain its state license or did not conduct hospital operations throughout a state fiscal year, the assessment for the state fiscal year in which the cessation occurs will be adjusted by multiplying the annual assessment computed under Ark. Code Ann. § 20-77-1902 by a fraction, the numerator of which is the number of days during the year that the Hospital operated and the denominator of which is three hundred sixty five (365). The fraction will be expressed as a percentage rounded to two places (Example – 65.23%).

Immediately upon ceasing to operate, the Hospital will pay the adjusted assessment for that state fiscal year to the extent not previously paid.

The Hospital also shall receive payments under Ark. Code Ann § 20-77-1908 for the state fiscal year in which the cessation occurs, which will be adjusted by the same fraction as its annual assessment.

A Hospital subject to an assessment under the Act that has not been previously licensed as a Hospital in Arkansas and that commences hospital operations during a state fiscal year will pay the required assessment computed under Ark. Code Ann. § 20-77-1902 and will be eligible for Hospital access payments under Ark Code Ann § 20-77-1908. The assessment will be calculated based on the effective date of licensure. The assessment for the state fiscal year in which the change occurs will be adjusted by multiplying the annual assessment computed under Ark. Code Ann. § 20-77-1902 by a fraction, the numerator of which is the number of days during the year that the Hospital is subject to the assessment and the denominator of which is three hundred sixty five (365). The fraction will be expressed as a percentage rounded to two places (Example – 65.23%).The Hospital also shall receive payments under Ark. Code Ann § 20-77-1908 for the state fiscal year in which the hospital is licensed, which will be adjusted by the same fraction as its annual assessment. Access payments and assessment fees

will not be reimbursed or collected until enrollment of the new provider has been approved by the Medicaid Provider Enrollment Section.

For new Hospitals determined to be located in an urban Metropolitan Statistical Area, the State will calculate revenue to be assessed based on a per licensed bed amount. The per licensed bed amount will be assigned and calculated based on the weighted average revenue per licensed bed amount for all other urban Hospitals in the State that are currently being assessed based on their cost reported revenue. Average revenue per licensed bed will be used in this way until the first unaudited cost report is received by the Department. The first unaudited cost report will not be used retroactively but will only be used to calculate the Hospital assessment amount for the next SFY annual assessment period. Unaudited cost reports will be used in this way until the first audited cost report is available. The first audited cost report will not be used retroactively but will only be used to calculate the Hospital assessment amount for the next SFY annual assessment period.

For new Hospitals determined to be located in a rural Non-Metropolitan Statistical Area, the State will calculate revenue to be assessed based on a per licensed bed amount. The per licensed bed amount will be assigned and calculated based on the weighted average revenue per licensed bed amount for all other rural Hospitals in the State that are currently being assessed based on their cost reported revenue. Average revenue per licensed bed will be used in this way until the first unaudited cost report is received by the Department. The first unaudited cost report will not be used retroactively but will only be used to calculate the Hospital assessment amount for the next SFY annual assessment period. In order for an unaudited cost report to be used to calculate the annual assessment amount for a hospital, the cost report must be received by the Department before July 1st of the state fiscal year (SFY) for which the assessment amounts will be collected. Unaudited cost reports will be used in this way until the first audited cost report is received. The first audited cost report will not be used retroactively but will only be used to calculate the Hospital assessment amount for the next SFY annual assessment period. 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. In order to be used to calculate the assessment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1st of the state fiscal year (SFY) for which the assessment will be collected.

For new Hospitals seeking Long Term Acute Care (LTAC) status by Medicare, the State will calculate revenue to be assessed based on a per licensed bed amount. The per licensed bed amount will be assigned and calculated based on the weighted average revenue per licensed bed amount for all other LTACs in the State that are currently being assessed based on cost report revenue.

Average revenue per licensed bed will be used in this way until the first unaudited cost report is received by the Department. The first unaudited cost report will not be used retroactively but will only be used to calculate the Hospital assessment amount for the next SFY annual assessment period. Unaudited cost reports will be used in this way until the first audited cost report is available. The first audited cost report will not be used retroactively but will only be used to calculate the Hospital assessment amount for the next SFY annual assessment period.

A Hospital that is exempted from payment of the assessment under Ark. Code Ann §20-77-1905 at the beginning of a state fiscal year but during the state fiscal year experiences a change in status so that it becomes subject to the assessment will pay the required assessment computed under Ark. Code Ann § 20-77-1902 and will be eligible for Hospital access payments under Ark. Code Ann § 20-77-1908. The assessment will be calculated based on the effective date of status change as determined by the Medicaid Provider Enrollment Section. The assessment for the state fiscal year in which the change occurs will be adjusted by multiplying the annual assessment computed under Ark. Code Ann. § 20-77-1902 by a fraction, the numerator of which is the number of days during the year that the Hospital is subject to the assessment and the denominator of which is three hundred sixty five (365). The fraction will be expressed as a percentage rounded to two places (Example – 65.23%).The Hospital also shall receive payments under Ark. Code Ann § 20-77-1908 for the state fiscal year in which the hospital status change occurs as determined by the Medicaid Provider Enrollment Section, which will be adjusted by the same fraction as its annual assessment. Access payments and assessment fees will not be reimbursed or collected until enrollment due to the status change has been approved by the Medicaid Provider Enrollment Section.

A Hospital that is subject to payment of the assessment computed under Ark. Code Ann. § 20-77-1902 at the beginning of a state fiscal year but during the state fiscal year experiences a change in status so that it is no longer subject to payment under Ark. Code Ann. § 20-77-1905 shall be relieved of its obligation to pay the Hospital assessment and shall become ineligible for Hospital access payments under Ark. Code Ann. §20-77-1908. The assessment for the state fiscal year in which the change occurs will be adjusted by multiplying the annual assessment computed under Ark. Code Ann. § 20-77-1902 by a fraction, the numerator of which is the number of days during the year that the Hospital was subject to the assessment and the denominator of which is three hundred sixty five (365). The fraction will be expressed as a percentage rounded to two places (Example – 65.23%).Immediately upon changing status, the Hospital will pay the adjusted assessment for that state fiscal year to the extent not previously paid. The Hospital also shall receive payments under Ark. Code Ann § 20-77-1908 for

the state fiscal year in which the status change occurs. The amount payable will be adjusted by the same fraction as its annual assessment.

FEE BILLING AND COLLECTION

The annual assessment imposed under Ark Code Ann. § 20-77-1902 is due and payable quarterly. However, an installment payment of an assessment imposed by Ark. Code Ann. § 20-77-1902 will not be due and payable until:

(A) The Division issues the written notice required by Ark. Code Ann. § 20-77-1907(a) stating that the payment methodologies to hospitals required under Ark. Code Ann. § 20-77-1908 have been approved by the Centers for Medicare and Medicaid Services and the waiver under 42 C.F.R. § 433.68 for the assessment imposed by Ark. Code Ann. § 20-77-1902, if necessary, has been granted by the Centers for Medicare and Medicaid Services; and

(B) The Division receives all needed information or the thirty-day verification period required by § 20-77-1907(b) has expired, whichever is later; and

(C) The Division has made all quarterly installments of inpatient and outpatient hospital access payments that were otherwise due under Ark. Code Ann. § 20-77-1908 consistent with the effective date of the approved state plan amendment and waiver.

After the initial installment has been paid under this section, each subsequent quarterly installment payment of an assessment imposed by Ark. Code Ann. § 20-77-1902 will be due and payable within ten (10) business days after the hospital has received its inpatient and outpatient Hospital access payments due under Ark. Code Ann. § 20-77-1908 for the applicable quarter by Accounts Receivable.

Failure of any facility to provide required reports or pay fees on a timely basis may result in the withholding of Medicaid reimbursement, letters of caution, sanctions or penalty assessment. Penalty assessments are detailed in the Sanctions Section identified below. The penalty assessment and outstanding Hospital assessment fee shall accrue interest at the maximum rate permitted by law from the date the assessment fee is due until payment of the assessment fee and the penalty assessment. Accounts Receivable will initiate the collection process on the 1st of the month following the due date for payments not received or postmarked by close of business on the 10th day following the notice of Assessment Due. Outstanding accounts report will be forwarded to Division of Medical Services for determination of further action.

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ADMINISTRATION OF FEES

Fees assessed and collected will be deposited in a designated account known as the Hospital Assessment Account, within the Arkansas Medicaid Program Trust Fund as established under Ark. Code Ann. §19-5-985.

SANCTIONS

The Division will sanction facilities that fail to comply with Ark Code Ann. §20-77-1901-1910, these regulations, or both. If a Hospital fails to timely pay the full amount of a quarterly assessment, the Division shall add to the assessment:

(A) A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date; and
(B) An additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts remaining on the last day of each quarter after the due date until the assessed amount and the penalties are paid in full,

Payments will be credited first to unpaid quarterly amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

Any fee or penalty assessment imposed under these regulations, as authorized by the Act, shall accrue interest at the maximum rate permitted by law from the date the fee or penalty assessment is imposed until the Facility pays the fee or penalty assessment.

For the purposes of these administrative procedures, “postmarked” will 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.

Recoupment Provisions

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

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APPEAL PROCEDURES

Appeal procedures for Hospitals are outlined in Attachment 4.19-A, Page 9e of the Medicaid State Plan. Facilities can obtain a copy of these procedures by contacting the Provider Reimbursement Unit at (501) 682-8308.

REFERENCES

Act 562 of the Regular Session of the 87th General Assembly ("the Act"). Effective March 24, 2009

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*.