

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.

PROPOSED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: 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 **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.