## Table of Contents

**State/Territory Name: Arkansas**

**State Plan Amendment (SPA) #: 24-0011**

This file contains the following documents in the order listed:


1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

**Financial Management Group**

September 12, 2024

Janet Mann
Deputy Secretary and Medicaid Director
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

RE: TN 24-0011

Dear Janet Mann:

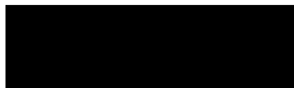
The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Arkansas state plan amendment (SPA) to Attachment 4.19-A AR 24-0011, which was submitted to CMS on April 5, 2024. This plan amendment changes the calculation of supplemental inpatient access payments for private hospitals.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of April 6, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan page.

If you have any additional questions or need further assistance, please contact Diana Dinh at 670-290-8857 or via email at Diana.Dinh@cms.hhs.gov.

Sincerely,



Rory Howe
Director
Financial Management Group

Enclosures

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 2 4 — 0 0 1 1

2. STATE: A R

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT
   - (●) XIX
   - ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 4/6/2024

5. FEDERAL STATUTE/REGULATION CITATION: 1902(a)(13)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
   - a. FFY 2024 $ 24,480,000
   - b. FFY 2025 $ 48,375,200

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: ATTACHMENT 4.19-A, Page 11d

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: ATTACHMENT 4.19-A, Page 11d

9. SUBJECT OF AMENDMENT

Delete requirement to apply Respective Case Mix Indexes (CMI) to both the base Medicare per discharge rates and base Medicaid per discharge rates for comparison to the Medicare-related UPL.

10. GOVERNOR'S REVIEW *(Check One)*
   - [x] GOVERNOR'S OFFICE REPORTED NO COMMENT
   - [ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
   - [ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
   - [ ] OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

12. TYPED NAME: Elizabeth Pitman

13. TITLE: Director, Division of Medical Services

14. DATE SUBMITTED: April 5, 2024

15. RETURN TO

Office of Rules Promulgation
PO Box 1437, Slot S295
Little Rock, AR 72203-1437

Attn: Mac Golden

**FOR CMS USE ONLY**

16. DATE RECEIVED: April 5, 2024

17. DATE APPROVED: September 12, 2024

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL: April 6, 2024

19. SIGNATURE OF APPROVING OFFICIAL: [redacted]

20. TYPED NAME OF APPROVING OFFICIAL: Rory Howe

21. TITLE OF APPROVING OFFICIAL: FMG, Director

22. REMARKS

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES**
**Revised: April 6, 2024**

---

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) 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, reimbursement for inpatient hospital services that were delivered by the private hospitals identified in step one.
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.
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 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.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30 for Inpatient Hospital Access Payments. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.