# Department of Human Services Response to Public Comments Regarding Rule 325 - Clarification of Requirements for an Acute Rehabilitation Unit within a Hospital and Update to the Medicaid Utilization Management Program (MUMP)

DHS confirms that this rule applies to all inpatient hospitals. The purpose of this rule change is to ensure that Medicaid funds are used appropriately to pay for the actual services being rendered. This promotes the "proper and efficient operation" of the Arkansas Medicaid State Plan and prevents waste of limited resources. DHS acknowledges that the provision of rehabilitation services within an inpatient hospital is sometimes the best option for a patient; however, hospitals should be paid according to the type of services being provided on each day of the patient's stay, not the type of license issued to the hospital.

Based on a comment submitted by Arkansas Children's Hospital, DHS published the proposed rule for a second public comment period to clarify the application of the rule to services provided to beneficiaries aged 18 and under. The only comment received during the second public comment period asked for further clarification; therefore, as a logical outgrowth of the public comment process, DHS will amend the last paragraph on Page 9a of Attachment 4.19-A of the Arkansas Medicaid State Plan as follows:

> Effective for dates of service on or after July 1, 2026, all inpatient acute care hospitals, including Pediatric Hospitals, Border City University-Affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals, Inpatient Psychiatric Hospitals, Out-of-State Hospitals, and Critical Access Hospitals, are reimbursed at the same hospital-specific prospective per diem rates used for Rehabilitative hospitals when only rehabilitative services are provided in an acute care setting. These rates are subject to an upper limit with no cost settlement. Rates will be effective July 1 of each year. The rate year is State fiscal year, July 1 through June 30.

(The entire paragraph is new language proposed in this rulemaking; the underlined portion is clarifying language added based on the public comments.)

DHS has determined that this rule change is necessary to meet the requirements of administration of the Arkansas Medicaid program. Specifically, 42 CFR 455.1(a)(2) requires the State to "[h]ave a method to verify whether services reimbursed by Medicaid were actually furnished to beneficiaries." Clearly, the use of Medicaid funds is intended to be limited by the type of service provided to the beneficiary. If a hospital is not actually furnishing acute

care services to a beneficiary, then Arkansas Medicaid should not pay for acute care services. Arkansas Medicaid should pay at the appropriate rate for the services that were actually furnished.

Additionally, Arkansas Medicaid statutes support this policy. A provision of the Medicaid Fairness Act allows for "reimbursement at an alternate level instead of complete denial." See Ark. Code Ann. § 20-77-1706. Specifically, in the case of retrospective reviews, if DHS has sufficient documentation to approve a level of care other than the one that was claimed, the agency may recoup the difference between the amount previously paid and amount that would have been paid for the appropriate level of care. For prior authorizations, DHS shall approve the request at the appropriate level of care.

The detailed portions of this rule that amend provider manuals are intended to provide clarity to providers regarding the standards that DHS will use when evaluating the medical necessity of rehabilitation services provided in acute care hospitals.

## Public Comments Regarding Rule 325 - Clarification of Requirements for an Acute Rehabilitation Unit within a Hospital and update to the Medicaid Utilization Management Program (MUMP)

**Second Comment Period: 06/06/26 – 07/06/26**

**Kelley Linck**

**Comment:** In the proposed rule packet on page 26, the last paragraph states (with edits):

Effective for dates of service on or after July 1, 2026, inpatient hospitals are reimbursed at the same hospital specific prospective per diem rates used for Rehabilitative hospitals when only rehabilitative services are provided in an acute care setting. These rates are subject to an upper limit with no cost settlement. Rates will be effective July 1 of each year. The rate year is Sate fiscal year, July 1, through June 30.

Question:

Can you clarify that this is intended to apply to all types of inpatient hospitals i.e. specialty hospitals, pediatric hospitals, border-city hospitals, teaching hospitals, etc ?

**First Comment Period: 04/19/26 - 05/18/26**

**Brent Thompson, Executive Vice President and Chief Legal and Administrative Officer, via email from Donna Collier, PACE, on behalf of Arkansas Children's Hospital**

**Comment:** Arkansas Children's Hospital (ACH) appreciates the opportunity to comment on the proposed rule and accompanying State Plan Amendment TN: 26-0001 (the "Proposed Rule"), published April 17, 2026. The Proposed Rule would (1) establish new clinical criteria for acute inpatient rehabilitation services provided within acute care hospitals, (2) change the reimbursement methodology for rehabilitation-only inpatient days at acute care hospitals from the existing hospital-class methodology to the rehabilitative hospital prospective per diem rate,[1] and (3) extend the Medicaid Utilization Management Program (MUMP) threshold from four days to seven days before requiring utilization review certification.

Our understanding from the Notice of Rulemaking is that the regulatory changes and state plan amendment are designed "for hospital services when a beneficiary is twenty-one years or older." The primary purpose of this comment letter is to confirm there is no intent to change the regulatory, clinical, or reimbursement structure currently governing the provision of services to patients under twenty-one years of age because of the wide-ranging impact of a potential change to the structure of pediatric services in Arkansas. ACH is the state's only provider of pediatric quaternary care, which means it treats the most expansive range of children's healthcare needs contemplated under our healthcare system. Isolating rehabilitation aspects of that care for distinct treatment within that system would present a host of concerns described further in this letter.

ACH supports the proposed extension of the MUMP threshold from four days to seven days, which reduces administrative burden without compromising medical necessity review. We have significant concerns about the rehabilitation reimbursement provisions if the intent is to apply those limitations to children's hospitals in the absence of pediatric considerations in the regulatory structure, clinical criteria, or reimbursement design of the Proposed Rule.

These comments incorporate by reference the analysis ACH provided January 6, 2025, in response to the Arkansas Department of Human Services' ("the Department's") November 15, 2024 referral to the Office of the Medicaid Inspector General (OMIG).[2] These comments also reflect the regulatory backdrop established by the OMIG's November 3, 2025 Report and Recommendations.[3] Copies of these materials are included with this letter.

I. The Existing Regulatory and Reimbursement Architecture

Arkansas Medicaid reimburses pediatric hospitals on a cost basis, paying interim per-diems, with a year-end cost settlement and consistent under-21 carve-outs across the State Plan and the Provider Manuals. Inpatient rehabilitation facilities are reimbursed on a prospective per diem basis with no cost settlement, subject to participation requirements (Department licensure and Medicare certification) that ACH does not satisfy. Inpatient rehabilitation facilities are also subject to a separate, distinct provider manual. The Proposed Rule would not reconcile these differences.

A. The Arkansas Medicaid State Plan Treats Hospitals Distinctly by Class

The State Plan and our state's associated regulations reflect the principle that hospital reimbursement must address operational realities, patient needs, and the challenges of providing healthcare services to different categories of patients, not a single methodology applied uniformly. The Arkansas Medicaid State Plan recognizes seven distinct hospital classifications, each with its own carefully calibrated regulatory, clinical, and reimbursement framework: acute care/general hospitals[4] pediatric hospitals[5], border city university-affiliated pediatric teaching hospitals[6], Arkansas State Operated Teaching Hospitals[7], rehabilitative hospitals[8], inpatient psychiatric hospitals[9], out-of-state hospitals[10], and critical access hospitals.

Each of the Department's deliberate policy decisions, approved by the Centers for Medicare & Medicaid Services (CMS) and developed over years of services and regulatory development, affects hospital types facing unique cost structures, regulatory frameworks, and service profile, each warranting a tailored methodology.

B. Pediatric Hospital Reimbursement is Cost-Based and Cost-Settled

Arkansas reimburses children's hospitals for inpatient services using a cost-based methodology, with interim per diem rates, and year-end cost settlements under reasonable cost principles.[11] That process generally proceeds in the following order:

- A children's hospital submits an annual cost report;
- During the year the hospital receives interim per diem payments, based on the prior year's cost report;
- After the cost reporting period closes, the State performs a year-end cost settlement reconciling total interim payments to allowable costs;[12]
- DHS can adjust the daily rate based on case-mix changes, the existing tool for handling shifts in the cost composition of care;[13]
- ACH either refunds amounts over its costs or is reimbursed the difference

between prior payments and costs after conclusion of the cost settlement process; and (as a result)

- Children's hospital reimbursement from the Department ultimately reflects the cost of the services provided to the Medicaid and uninsured patient population.

Pediatric hospitals are exempt from the per diem cost limit that applies to general acute care hospitals at cost settlement because of the structural recognition that a children's hospital has cost characteristics that cannot fit within an acute-care general per diem ceiling[14]. Outpatient services at pediatric hospitals are likewise reimbursed on a cost basis, with cost report and settlement[15], and direct medical education costs (including graduate medical education) are reimbursed under Medicare rules in place since the 1980s.[16]

As a result, while ACH receives a daily rate for services, calculated through cost-based methodology, this rate is ultimately subject to a year-end cost settlement against actual costs. ACH's final reimbursement reflects the actual cost of providing pediatric quaternary care, including services in the state's only Level IV neonatal intensive care unit (NICU) and the highest-level pediatric intensive care unit (PICU) in the state of Arkansas.

The current Hospital/Critical Access Hospital/ESRD Provider Manual establishes the inpatient benefit limit framework that the Proposed Rule operates within. The benefit limit provision provides: "There is no benefit limit for acute care/general and rehabilitative hospital inpatient services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program."[17] The 24-day annual benefit limit applies only to beneficiaries aged 21 and older.[18] When a beneficiary turns 21 during an inpatient stay, the dates of service on or after the 21st birthday are billed separately, demonstrating DHS operates a robust system separating pediatric from adult claims.[19]

C. Inpatient Rehabilitation Facilities Are a Distinct Provider Type

Inpatient rehabilitation facilities are a distinct provider type. DOH licenses hospitals as either "acute care/general" or as "inpatient rehabilitation," with no "acute care rehabilitation" license category.[20] The two licenses come with materially different physical environment, operational, and staffing requirements.[21] The Medicaid State Plan establishes a prospective per diem methodology with no cost settlement for rehabilitative hospitals, capped at the 70th percentile of all rehabilitative hospitals' inflation-adjusted Medicaid per diem rate.[22] For recipients aged 21 and older, the State Plan further provides a prospective per diem rate for rehabilitative hospital days beyond the 24-day MUMP cap.[23] ACH does not hold an inpatient rehabilitation license, is not Medicare-certified as a Rehabilitative Hospital, and is not enrolled as a rehabilitative hospital.

The Rehabilitative Hospital Provider Manual separately establishes participation requirements for rehabilitative hospitals. To participate in the Arkansas Medicaid Program as a rehabilitative hospital, a facility must (a) be licensed by the Arkansas Department of Health ("DOH") as a Rehabilitative Hospital and (b) be certified as a Rehabilitative Hospital Title XVIII (Medicare) provider.[24] The license and Medicare certification must accompany the provider application and contract.[25] These are the existing regulatory gateways to rehabilitative hospital reimbursement under the State's Medicaid program. Acute care hospitals do not satisfy them, and the Proposed Rule does not amend them.

## II. Comments on the Proposed Rule

### A. The Proposed Rule and SPA Should Clarify an Age-Based Carve-Out for Beneficiaries Under Twenty-One Years of Age

ACH respectfully requests that DHS clarify and confirm a critical scope question. The Notice of Rule Making published by DHS contains the following statement:

> "The rule details billing for hospital services when a beneficiary is twenty-one years or older. DHS will submit a state plan amendment to be effective July 1, 2026, stating that inpatient hospitals will be reimbursed at the same hospital-specific prospective per diem rates used for rehabilitative hospitals when only rehabilitative services are provided in acute care settings."

There are deletions at 213.220 and 212.401 that seem inconsistent with the Notice of Rule Making in that it deletes the clarifying language related to beneficiaries twenty-one years or older. We approach the remainder of these comments under the assumption that DHS intends this Proposed Rule to apply only to beneficiaries 21 and older. That assumption is consistent with the rest of the Arkansas Medicaid regulatory architecture, which consistently carves out children from per diem caps, day limits, and benefit limitations:

- Both the Hospital and Rehabilitative Hospital Provider Manuals open their inpatient benefit limit sections with the identical sentence that there is "no benefit limit for acute care/general and rehabilitative hospital inpatient services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program."[26]
- Attachment 4.19-A, Page 1 expressly excludes under-21 beneficiaries from the prospective per diem cap that applies to inpatient services beyond 24 days for adults.
- Attachment 4.19-A, Page 9a (the existing Rehabilitative Hospital provision the Proposed Rule purports to extend) likewise applies the prospective per diem rate only "for recipients age 21 and older."

- Attachment 3.1-A, Page 1a excludes EPSDT recipients from the 24-day inpatient benefit limit and entirely waives the four-day MUMP threshold for individuals under age 1.
- Attachment 3.1-A, Page 1aa (rehabilitative hospital provisions) preserves extended Augmentative Communication Device benefits "for individuals under age 21."
- Federal law independently requires that all medically necessary EPSDT services be provided to children under 21.[27]

Against that structure, the proposed amendment to Attachment 4.19-A, Page 9a reads:

> "Effective July 1, 2026, inpatient hospitals are reimbursed at the same hospital-specific prospective per diem rates used for rehabilitative hospitals when only rehabilitative services are provided in acute care settings, subject to an upper limit, with no cost settlement."

This text contains no reference to beneficiary age, no carve-out for pediatric hospitals, and no preservation of the cost-based methodology for children under 21. ACH therefore requests that DHS confirm in writing that the Proposed Rule does not apply to beneficiaries under 21 years of age, and that DHS amend the rule text; a potential clarifying sentence could state:

> "This methodology applies only to beneficiaries who are twenty-one (21) years of age or older. Rehabilitation services provided to beneficiaries under twenty-one (21) years of age in the Child Health Services (EPSDT) Program continue to be reimbursed under the methodology applicable to the hospital classification of the facility providing the service."

The remainder of these comments addresses the consequences of including children's facilities in the proposed methodology, both because the rule text as currently drafted may be construed to do so and because the issues raised remain relevant if DHS later considers expanding the rule's scope.

B. Regulatory and Licensing Implications of the Proposed Rule

1. The Proposed Rule Bypasses Existing Rehabilitative Hospital Participation Requirements

The Proposed Rule's reimbursement methodology cannot be reconciled with the existing participation requirements for rehabilitative hospital reimbursement. The Rehabilitative Hospital Provider Manual requires that to participate in the Arkansas Medicaid Program as a rehabilitative hospital, a facility must (a) be licensed by the Department as a Rehabilitative Hospital and (b) be certified as a Rehabilitative Hospital Title XVIII (Medicare) provider.[28] The

current license and current Medicare certification must accompany the provider application and contract.[29]

ACH does not satisfy these participation requirements. ACH holds an acute care/general license, not a rehabilitative hospital license. ACH is not Medicare-certified as a Rehabilitative Hospital. ACH is not enrolled with Arkansas Medicaid as a Rehabilitative Hospital. The Proposed Rule effectively pays acute care hospitals at rehabilitative hospital rates without requiring that those hospitals satisfy the rehabilitative hospital participation requirements. This is internally inconsistent with the existing regulatory architecture. If these requirements apply to all rehabilitative hospital reimbursement, then acute care hospitals cannot be paid at those rates because they do not qualify. If they do not apply, then the Proposed Rule creates a new and uncodified category of "rehabilitative hospital reimbursement without rehabilitative hospital participation," and the rulemaking record should identify the regulatory authority for that category.

2. DOH Licensure Does Not Recognize an "Acute Care Rehabilitation" Hybrid

Beyond participation requirements, the Proposed Rule assumes a hybrid regulatory category that does not exist in DOH licensure. DOH issues an "acute care/general" license or an "inpatient rehabilitation" license; there is no "acute care rehabilitation" license.[30] The two licenses come with materially different physical environment, operational, and staffing requirements. ACH holds an acute care/general license. The Acute Care Rehabilitation Unit, which comprises 10 beds on ACH's fifth floor, is part of ACH's acute care/general operation, not a separate facility or a lower level of acuity. ACH cannot, as a matter of regulatory architecture, be treated as a rehabilitative hospital for purposes of Attachment 4.19-A, Page 9a reimbursement while remaining an acute care/general hospital for licensure, certification, supplemental payment program eligibility, and every other purpose.

3. Federal CMS Certification Requirements Independently Block Concurrent Operation

Even setting aside licensure and Arkansas Medicaid participation requirements, federal CMS certification requirements independently block the configuration the Proposed Rule appears to contemplate. ACH's January 6, 2025, letter discussed these requirements in detail[31], and ACH respectfully incorporates that analysis here. The principal points are summarized below.

Conditions for IRF PPS exclusion. To be paid under the Inpatient Rehabilitation Facility (IRF) prospective payment system rather than the inpatient acute care PPS, an IRF (whether freestanding or as a unit of an acute care hospital) must satisfy its own regulatory conditions.[32] Among the requirements: the IRF must have beds "physically separate from (that is, not commingled with) the hospital's other beds,"[33] written admission criteria applied uniformly

to Medicare and non-Medicare patients, separate admission and discharge records, separate cost center treatment, and an accounting system that properly allocates costs between the IRF and the rest of the hospital.[34]

Hospital-within-hospital requirements. For a unit operated within an acute care hospital that occupies space in a building also used by another hospital not excluded from the inpatient prospective payment system (IPPS), the unit must satisfy a series of separation requirements[35]:

- Separate governing body. The hospital must have a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus;
- Separate chief medical officer. The hospital must have a single chief medical officer who reports directly to the governing body, and the CMO cannot be employed by or under contract with the other hospital;
- Separate medical staff. The hospital must have a medical staff that is separate from the medical staff of the hospital occupying space in the same building, accountable directly to the governing body and operating under its own bylaws;
- Separate chief executive officer. The hospital must have a single CEO through whom all administrative authority flows; the CEO cannot be employed by or under contract with the other hospital;
- Performance of basic hospital functions. The hospital must perform its basic hospital functions through its own employees or through contracts with entities other than the hospital occupying space in the same building.

Operational integration restrictions. The CMS State Operations Manual provides "departments of separately certified hospitals with one system governing body cannot be operationally integrated."[36] Each hospital must have its own nursing service, its own nursing staff schedule, and its own quality assessment and performance improvement (QAPI) program. Nurses cannot be moved back and forth between hospitals on an ad hoc, as needed basis. Each hospital must have a separate work schedule, even if the same individual serves as Director of Nursing for both.[37]

IRF classification criteria. An IRF must serve an inpatient population of whom at least 60 percent require intensive rehabilitation services for one or more enumerated conditions, including stroke, spinal cord injury, brain injury, certain orthopedic conditions, and others.[38] The IRF must also have a director of rehabilitation who is a physician with at least two years of training or experience in medical management of inpatients requiring rehabilitation services, in addition to a one-year hospital internship.[39] A provider focused on a pediatric

population that does not satisfy the 60% adult-IRF condition list compliance test. The pediatric attending physician model differs from the rehabilitation physician model embedded in the regulations as well.

The cumulative effect of these federal requirements is that an acute care hospital cannot, without substantial structural reconfiguration, operate any of its beds under IRF reimbursement principles. ACH would be required to create a new, independent governance structure, a new medical staff, separate accounting systems, and physical reconfiguration of unit space, all to address services that account for barely more than I% of patient days.

4. The Swing Bed Model Does Not Solve the Concurrent Operation Problem

ACH cannot use rehabilitation beds as swing beds, operating them as acute care beds when needed and as rehabilitation beds when needed. The CMS swing bed program exists to permit Critical Access Hospitals in rural areas to swing beds between acute care and skilled nursing.[40] ACH is not a Critical Access Hospital and is not in a rural area. The swing bed framework does not extend to inpatient rehabilitation. IRF beds must be "physically separate from (that is, not commingled with) the hospital's other beds.[41]" Beds that swing between functions are commingled by definition. Any suggestion that ACH could swing the same beds between acute and rehabilitation reimbursement is foreclosed by federal regulation.

5. The Rehabilitation Structure Imposes Significant Operational Burdens

Beyond the regulatory architecture concerns, if applicable to pediatric services, the Proposed Rule imposes specific operational and administrative burdens:

- Real-time triage of inpatient days. ACH would need to determine, on a day-by-day basis, whether a child is receiving "rehabilitation only" services or acute care services, and bill accordingly. This determination is not always clinically clean, particularly for children whose progress through rehabilitation is non-linear and who frequently transition between acute care needs and rehabilitation needs within the same admission.

- Plan of Care synthesis within four days. Section 211.1 l0(A) of the Proposed Rule requires that the Plan of Care be synthesized by the rehabilitation physician within four days of receipt of "rehabilitation only" services. The cadence reflects the freestanding adult IRF rehabilitation physician model, not pediatric multidisciplinary team practice.

- Three hours per day or fifteen hours per week therapy participation. Section 211.100(E) requires that the beneficiary be able to actively participate in rehabilitation services for three hours per day or fifteen hours per week,

mirroring the Medicare IRF intensity standard[42]. Pediatric rehabilitation patients, particularly those recovering from traumatic brain injury, may not tolerate this intensity at all stages.

- Three rehabilitation physician visits per week. Section 211.120 requires face-to-face visits at least three days per week. ACH's pediatric attending physician model differs from a freestanding IRF's rehabilitation physician model.

- DOH physical environment specifications. Code Ark. R. 007.35.8-41 et seq. imposes detailed physical environment requirements on rehabilitation hospitals, including individual patient toilet rooms, 55 square feet per bed of dining/recreation/day space, dedicated activities-of-daily-living training units, and various other space and finish requirements. ACH's acute care/general license and physical configuration do not satisfy these requirements, and significant capital investment would be required to modify existing space, with no corresponding increase in capacity to treat children.

These requirements would impose ongoing compliance, documentation, and audit risk costs. The implementation cost would be disproportionate to the clinical population served.

6. The Proposed Rule Raises Federal Concerns Regarding Access and EPSDT Sufficiency

If the Proposed Rule is construed to apply to children under 21, it would raise serious concerns under federal law. *First,* under Section 1902(a)(30)(A) of the Social Security Act, state Medicaid payment methods must be "consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[43] Reimbursing rehabilitation services at ACH at rates derived from adult rehabilitation hospital cost data, capped at the 70th percentile, falls below the cost of providing those services in a pediatric quaternary care setting. A potential consequence is reduction of pediatric rehabilitation availability at the only quaternary pediatric provider in Arkansas. *Second,* under the EPSDT mandate, Medicaid must provide all medically necessary diagnostic, screening, preventive, and treatment services for children under 21.[44] The EPSDT mandate requires that services not just be covered on paper but be available in fact.[45] A rule that systematically underpays pediatric rehabilitation services threatens the actual availability of those services.

C. Comments Regarding Quality and Availability of Care

1. The Proposed Clinical Criteria Are Designed for Adult JRFs and Do Not Reflect Pediatric Rehabilitation Practice

The clinical criteria in proposed Section 211.100 closely track the Medicare Inpatient Rehabilitation Facility compliance requirements.[46] The Medicare IRF framework was developed for and validated against adult populations. Several elements warrant pediatric-specific analysis before they are applied to children's services:

The three hours per day intensity requirement. The Medicare 60% rule and the associated three hours per day or fifteen hours per week therapy intensity standard reflect adult rehabilitation tolerance[47]. Pediatric rehabilitation patients, particularly those recovering from traumatic brain injury, may not tolerate this intensity at all stages of recovery.

The condition list. The thirteen medical conditions listed at proposed Section 211.125 reflect the Medicare IRF condition list.[48] Several of those conditions are predominantly or exclusively adult: severe or advanced osteoarthritis involving two or more major weight-bearing joints, knee or hip joint replacement, fractures of the femur in geriatric populations, and Parkinson's disease, among others. Conditions that drive pediatric rehabilitation, such as congenital cardiac surgery recovery, complex pediatric oncology rehabilitation, and pediatric musculoskeletal procedures, do not appear on the list.

The rehabilitation physician model. The proposed requirement that beneficiary services be supervised by a rehabilitation physician with face-to-face visits at least three days per week reflects the freestanding adult IRF model.[49] Pediatric rehabilitation in a quaternary care setting typically follows a multidisciplinary team model.

The discharge and family caregiver expectations. Section 211.11O(D) provides that family members and caregivers identified prior to or during admission are expected to participate in the plan of care and discharge planning. Pediatric rehabilitation already operates under family-centered care principles, but the specific cadence and intensity of family participation differ when the patient is a child.

2. Pediatric Rehabilitation Care Has Distinct Quality and Safety Requirements

Pediatric quaternary care includes infrastructure and staffing that adult IRFs are not required to maintain and, in most cases, do not maintain. Examples include:

- Pediatric intensive care unit immediately accessible for clinical deterioration.
- Pediatric anesthesia and pediatric surgical services available 24/7.
- Pediatric subspecialty consultation across cardiology, neurology, neurosurgery, orthopedics, pulmonology, and other disciplines.
- Pediatric-trained nursing staff with the higher staffing ratios that pediatric care requires.
- Child life services to support emotional, developmental and educational needs during hospitalization.
- Pediatric pharmacy with weight-based dosing infrastructure.

- Family-centered care models with rooming-in capacity, parent education, and pediatric social work.
- Developmental specialists who can assess and plan for the child's developmental trajectory in addition to functional rehabilitation.

These resources exist at ACH because they are required to safely and effectively care for medically complex children. They are not required for a freestanding adult IRF, which serves a population that does not have these specific clinical needs.

3. Volume and Capacity Context

The clinical and access concerns must be considered in the context of ACH's actual operations:

- In 2024, ACH provided acute care rehabilitation services to approximately 48 patients, representing 0.6% of total patients and 1.2% of total patient days.
- ACH's 10-bed Acute Care Rehabilitation Unit on the fifth floor sits within an 83,301-patient-day operation.
- ACH operates the only Level IV NICU and the highest-level PICU in Arkansas.
- Average daily census in those intensive care units continues to rise.

Allocating beds and space exclusively to a licensed inpatient rehabilitation facility within ACH (the structure the Proposed Rule's reimbursement methodology effectively requires) would constrain bed flexibility precisely as intensive care demand is growing. The opportunity cost is significant, and the Proposed Rule does not weigh it.

4. The Proposed Rule Creates a Barrier to Access for Pediatric Patients in Arkansas

The combined effect of the regulatory mismatch and the rate disparity is that the Proposed Rule, if applied to pediatric services, would create a barrier to access for the children who need pediatric rehabilitation in Arkansas. The unit serves children with complex rehabilitation needs that arise in the course of pediatric quaternary care: post-traumatic brain injury rehabilitation, post-spinal cord injury rehabilitation, post-surgical rehabilitation following complex pediatric orthopedic and neurological procedures, and rehabilitation following major medical events. If reimbursement is reduced from the cost-based methodology to a prospective per diem capped at the 70th percentile of rehabilitative hospital rates, the unit's reimbursement gap will widen substantially.

The realistic consequences of sustained below-cost reimbursement at the only quaternary pediatric provider in the state are:

- Reduction in unit capacity. ACH may have to reduce the number of beds

dedicated to the rehabilitation function and reallocate them to other clinical uses.

- Discontinuation of the unit. If sustained losses cannot be absorbed within ACH's overall financial structure, the rehabilitation function may have to be discontinued altogether.

- Children sent out of state. Children needing inpatient pediatric rehabilitation would have to seek care at out-of-state pediatric facilities, separating families from medically complex children at exactly the moment family involvement is most clinically and developmentally important.

- Cross-subsidization pressure. If ACH attempts to maintain the unit despite the reimbursement gap, the resulting losses must be absorbed somewhere. Cross-subsidization from other service lines is not a sustainable response.

D. Comments on Reimbursement Issues

1. The Pediatric Hospital Reimbursement Structure Is Architecturally Different and the Proposed Rule Does Not Reconcile the Difference

Pediatric hospitals are reimbursed differently from general acute care hospitals across every metric: base inpatient rates[50], outpatient rates[51], GME[52], supplemental payments[53], and assessment fee exemption[54]. This is not coincidence; the State Plan consistently recognizes pediatric quaternary care as a distinct cost structure from an acute-care general methodology.

The Proposed Rule disregards this architectural framework for one specific category of inpatient days. When a child at ACH is determined to be receiving "rehabilitation only" services, the rule shifts that day from cost-based to prospective per diem, from settled to unsettled, and from no-cap to capped at the 70th percentile of rehabilitative hospital rates.[55]

2. The Rehabilitative Hospital Per Diem Rate Is Not Calibrated to Pediatric Costs

The rehabilitative hospital per diem methodology under Attachment 4.19-A, Page 9a establishes rates based on each rehabilitative hospital's own unaudited cost report, trended forward by the Consumer Price Index, capped at the 70th percentile of all rehabilitative hospitals' inflation-adjusted Medicaid per diem rate.[56] If applied to ACH, the methodology presents an immediate calibration problem. ACH does not file a rehabilitative hospital cost report. ACH files a pediatric acute care/general hospital cost report. Two options exist, and neither works:

- Use rehabilitative hospital cost data. The resulting rate will systematically underpay ACH because it will reflect adult, not pediatric, cost structures, and freestanding rehabilitation infrastructure rather than embedded pediatric

quaternary care infrastructure.

- Use ACH's own cost data. ACH's cost data may produce a higher per diem than rehabilitative hospitals (reflecting actual cost differences), but the cap will pull it down to the rehabilitative hospital ceiling.

Inflation adjustment cannot fix this calibration problem. The CPI-U adjustment is a year-over-year inflation factor; it does not change the relationship between pediatric quaternary care costs and rehabilitative hospital costs. The calibration concern is not theoretical. In December 2025, DHS implemented an interim billing process for dates of service identified in OMPA Final Orders, applying prospective per diem rates of $1,667 (in-state rehabilitation per diem ceiling) and $400 (the 24-day cap rate that applies only to age 21 and older)[57]. This is the rate structure the Proposed Rule would generalize, with the same calibration problem.

*3.* The Proposed Rule Disrupts the Cost Settlement Mechanism

The Proposed Rule disrupts this mechanism for any inpatient days reclassified as "rehabilitation only." The proposed amendment to Page 9a explicitly provides that the rehabilitation per diem rates have no cost settlement.[58] For those days, DHS would lose the existing safeguard against overpayment. The State Plan provides a second tool: case-mix-based rate adjustment.[59] If DHS believes that the cost composition of ACH's patient population is changing in ways that warrant a rate adjustment, the existing State Plan provides the mechanism. No new rule is required. Both tools are prospective, transparent, and operate within the existing State Plan framework.

4. Downstream Effects on UPL, Access Payments, DSH, and Other Supplemental Payments

The Proposed Rule's reimbursement effects extend beyond the affected per-day rates. Several downstream effects warrant analysis that the Financial Impact Statement does not appear to address:

Cost settlement distortion. Removing rehabilitation-only days from the cost-settled population means that the remaining acute days bear a disproportionate share of fixed overhead.

UPL gap effects. Lower base Medicaid payments for rehabilitation-only days reduce the size of the UPL gap that drives Pediatric Inpatient Adjustment supplemental payments.[60] Even if the per diem reduction is offset by higher supplemental payments, the cap on supplemental payments at the federal upper payment limit may prevent full offset.

Inpatient Hospital Access Payments effects. Although ACH does not draw from the Inpatient Hospital Access Payments pool,[61] that pool is structured around the difference between Medicaid base payments and the Medicare UPL. Changes to base payments at participating hospitals will shift the size and distribution of access payments.

Disproportionate Share Hospital effects. Hospital-specific DSH limits depend on the relationship between Medicaid payments and Medicaid costs.[62] Reducing Medicaid payments

without reducing Medicaid costs increases the Medicaid shortfall component of the DSH calculation, with downstream consequences for DSH eligibility, allocation, and audit redistribution.

5. The Proposed Rule Operates as a Barrier to Access by Reducing the Sustainability of the Only Quaternary Pediatric Provider in the State

The reimbursement consequences of the Proposed Rule are inseparable from the access consequences. When reimbursement is reduced below cost for a meaningful subset of patient days, the sustainability of that provider is implicated. ACH does not have access to alternate payer mixes that would offset Medicaid losses at the same rate that adult hospitals do. Over 60% of ACH's payer mix is Medicaid. All other hospitals throughout the State rely on ACH to provide the vast majority of inpatient care for the pediatric population, Medicaid or otherwise. The Medicaid shortfall translates directly into operational pressure on the unit, the hospital, and ultimately the children of Arkansas. Cross-subsidization is not sustainable in the current Medicaid environment.

F. Specific Recommendations

Based on the foregoing comments, ACH respectfully offers the following recommendations:

1. Confirm and codify the under-21 exclusion. Consistent with DHS's representation in the Notice of Rule Making, expressly add to the Proposed Rule and to the State Plan amendment the clarifying language proposed in Section A above. This will align the rule text with the public notice and with the consistent under-21 carve-outs already in the Hospital and Rehabilitative Hospital Provider Manuals[63] and across the State Plan.[64]

2. Exempt pediatric hospitals from the rehabilitation per diem methodology. Independent of the under-21 question, exempt pediatric hospitals (as defined in Attachment 4.19-A, Page 4) from the rehabilitation per diem methodology of the Proposed Rule.

3. Reconcile the Proposed Rule with existing rehabilitative hospital participation requirements. To the extent the Proposed Rule pays acute care hospitals at rehabilitative hospital rates, the rule must address the existing participation requirements.[65] The rulemaking record should explain how an acute care hospital can be paid as a rehabilitative hospital without the licensure and Medicare certification that the existing rule requires.

4. Establish pediatric-specific clinical criteria. If DHS proceeds with clinical criteria for inpatient rehabilitation, establish pediatric-specific criteria that reflect pediatric rehabilitation literature, pediatric tolerance to therapy intensity, pediatric multidisciplinary team practice, and the pediatric conditions that drive rehabilitation.

5. Conduct comprehensive financial impact analysis. Before finalizing the Proposed Rule, prepare and publish a comprehensive financial impact analysis that addresses the downstream effects identified above, including UPL, Access Payments, DSH, and OBBBA cumulative effects.

6. Engage with pediatric stakeholders before finalization. ACH offers to provide additional data, including detailed information on the patient population, clinical profile, and cost structure of the Acute Care Rehabilitation Unit. We welcome the opportunity for direct engagement with DMS staff before the rule is finalized.

G. Conclusion

ACH submits these comments to support the development of a rule that achieves DHS's regulatory aims while preserving access to care for the children of Arkansas. We support the MUMP threshold extension. We support clarification of where rehabilitation services are appropriately delivered and reimbursed. We support DHS's policy authority to address billing through the rulemaking process, which is the proper forum for this kind of structural change.

The children we serve depend on a Medicaid reimbursement framework that recognizes the distinct cost, clinical, and operational realities of pediatric quaternary care. The State Plan and the Provider Manuals already establish that framework, with consistent under-21 carve-outs and structural recognition of pediatric distinctness. The Proposed Rule, as currently drafted, would partially override that framework for a small subset of patient days, but with downstream effects on access, supplemental payments, and federal compliance warranting more careful analysis than the rulemaking record currently contains. Our recommendations are designed to permit DHS to move forward with the policy clarification without disrupting the architecture that protects pediatric care. Thank you for the opportunity to comment on the Proposed Rule. Please do not hesitate to contact us if additional information would be helpful.

*Citations:*

*[1]State Plan Att. 4.19-A, p. 9a (Rehabilitative Hospitals).*

*[2]Letter from Brent L. Thompson, EVP & Chief Legal Officer, Arkansas Children's Hospital, to Secretary Allison Bragg, Department of Inspector General, Re: Response to Request for Preliminary Investigation: Arkansas Children's Hospital (Jan. 6, 2025) ("ACH January 6, 2025 Letter").*

*[3] Office of the Medicaid Inspector General, R&R, Case No. 2025-00136 (Nov. 3, 2025) ("OMIG Report").*

*[4] State Plan Att. 4.19-A, p. 1 (subject to per diem cost limit at year-end cost settlement).*

[5] *State Plan Att. 4.19-A, p. 4 (cost-based reimbursement); p. 4 ("a hospital is a pediatric hospital if it has in effect an agreement to participate as a hospital and the majority of its patients are individuals under the age of 21").*

[6] *State Plan Att. 4.19-A, p. 7.*

[7] *State Plan Att. 4.19-A, pp. 8-9a.*

[8] *State Plan Att. 4.19-A, p. 9a.*

[9] *State Plan Att. 4.19-A, pp. 9b-9bbb.*

[10] *State Plan Att. 4.19-A, pp. 10-11.*

[11] *State Plan Att. 4.19-A, p. 4 (incorporating HIM-15 / PRM-15 cost rules); 42 C.F.R. Part 413 (Medicare Principles of Reasonable Cost Reimbursement).*

[12] *State Plan Att. 4.19-A, pp. 4--6 (cost report and settlement procedure).*

[13] *State Plan Att. 4.19-A, p. 6 (case-mix adjustment); see also OMIG Report at 13 (identifying case-mix adjustment as an existing tool).*

[14] *State Plan Att. 4.19-A, p. 1 (excluding from the cost limit "Pediatric Hospitals, Border City University-Affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals, Rehabilitative Hospitals, Inpatient Psychiatric Hospitals, Out-Of-State Hospitals and Critical Access Hospitals").*

[15] *State Plan Att. 4.19-B, Section 2.a.(2) (cost-based reimbursement for pediatric hospital outpatient services, effective Apr. 1, 1992).*

[16] *State Plan Att. 4.19-A, p. 7 (GME reimbursement using pre-Sept. 29, 1989 Medicare reasonable cost rules); see also 54 Fed. Reg. 40,286 (Sept. 29, 1989).*

[17] *Ark. Admin. Code 016.06.20-212.401(A) (eff. Aug. 1, 2021); see also Ark. Admin. Code 016.06.41-213.0IO(A) (eff. Aug. 1, 2021) (identical sentence in the Rehabilitative Hospital Provider Manual).*

[18] *Ark. Admin. Code 016.06.20-212.401(B); 016.06.41-213.0IO(B).*

[19] *Ark. Admin. Code 016.06.41-213.0l0(C); see also Ark. Admin. Code 016.06.20-212.401(F) (referencing special billing instructions for beneficiaries who tum 21 during an inpatient stay).*

[20] *OMIG Report at 4 (DOH licenses hospitals as either "acute care/general" or "inpatient rehabilitation").*

[21] *20 CAR§ 43-139 (definition ofrehabilitation hospital); Code Ark. R. 007.35.8-41 et seq. (rehabilitative hospital licensure requirements, including services and qualifications, administrative requirements, medical record and treatment plan, physical environment and facilities, and design and construction standards).*

[22] *State Plan Att. 4.19-A, p. 9a.*

[23] *State Plan Att. 4.19-A, p. 9a (eff. Oct. 1, 2014, for recipients age 21 and older).*

[24] *Ark. Admin. Code 016.06.41-201.000 (Arkansas Medicaid Participation Requirements for Rehab. Hospitals).*

[25] *Ark. Admin. Code 016.06.41-201.000(A}-{B).*

[26] *Ark. Admin. Code 016.06.20-212.40l(A); 016.06.41-213.0l0(A) (both eff. Aug. 1, 2021).*

[27] *42 U.S.C. § 1396d(r); 42 U.S.C. § 1396a(a)(43); 42 C.F.R. Part 441, Subpart B; see also Pediatric Specialty Care, Inc. v. Arkansas Dep 't of Human Servs., 293 F.3d 472 (8th Cir. 2002).*

[28] *Ark. Admin. Code 016.06.41-201.000(A)-{B).*

[29] *Ark. Admin. Code 016.06.41-201.000.*

[30] *OMIG Report at 4; Code Ark. R. 007.35.8-41 et seq. (rehabilitative hospital licensure requirements).*

[31] *ACH January 6, 2025, Letter at 2-7 and accompanying Memorandum re: Regulatory and Licensing Requirements for Rehab Hospital Reimbursement.*

[32] *42 C.F.R. §§ 412.604 (basic conditions for payment under IRF PPS); 412.25 (conditions for exclusion ofIRFs and IPFs from the inpatient PPS).*

[33] *42 C.F.R. § 412.25(a)(7).*

[34] *42 C.F.R. § 412.25(a)(2)-(13).*

[35] *42 C.F.R. § 412.22(e).*

[36] *CMS State Operations Manual, Appendix A, at 41.*

[37] *CMS State Operations Manual, Appendix A, at 41.*

[38] *42 C.F.R. § 412.29(b).*

[39] *42 C.F.R. § 412.29(g).*

[40] *42 C.F.R. § 482.66 (post-hospital SNF care swing-bed approval); CMS, Skilled Nursing Facility (SNF) Swing-Bed Providers, https://www.cms.gov/medicare/payment/prospective-payment-systems/sk.illed-nursing-facility-snf/swing-bed-providers.*

[41] *42 C.F.R. § 412.25(a)(7)*

[42] *Medicare Benefit Policy Manual, CMS Pub. 100-02, ch. 1, § 110 (IRF coverage req.); 42 C.F.R. § 412.622.*

[43] *42 U.S.C. § 1396a(a)(30)(A).*

[44] *42 U.S.C. § 1396d(r); 42 U.S.C. § 1396a(a)(43); 42 C.F.R. Part 441, Subpart B.*

[45] *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs., 293 F.3d 472 (8th Cir. 2002) (enjoining Arkansas from cutting early intervention day treatment services determined medically necessary).*

[46] *42 C.F.R. § 412.29; Medicare Benefit Policy Manual, CMS Pub. 100-02, ch. 1, § 110.*

[47] *42 C.F.R. § 412.29(b)(l) (60% rule).*

[48] *42 C.F.R. § 412.29(b)(2).*

[49] *42 C.F.R. § 412.29(e)-(g).*

[50] *State Plan Att. 4.19-A, p. 4 (cost-based with cost settlement; no per diem ceiling).*

[51] *State Plan Att. 4.19-B, Section 2.a.(2).*

[52] *State Plan Att. 4.19-A, p. 7 (pre-Sept. 29, 1989 Medicare cost rules).*

[53] *State Plan Att. 4.19-A, p. 1lc (Private Pediatric Hospital Inpatient Adjustment).*

[54] *Ark. Code Ann.§ 20-77-1901(7).*

[55] *State Plan Att. 4.19-A, p. 9a.*

[56] *State Plan Att. 4.19-A, p. 9a.*

[57] *State Plan Att. 4.19-A, pp. 9a, 1.*

[58] *State Plan Att. 4.19-A, p. 9a ("with no cost settlement").*

[59] *State Plan Att. 4.19-A, p. 6 ("the State may adjust a hospital's operating costs upward or downward, as appropriate under circumstances" including changes in case mix); OMIG Report at 13.*

[60] *State Plan Att. 4.19-A, p. l lc; 42 C.F.R. § 447.272.*

[61] *State Plan Att. 4.19-A, p. 1 ld (calculated using the 97% UPL methodology); Ark. Code Ann.§ 20-77-1901(7) (specialty hospital exclusion).*

[62] *State Plan Att. 4.19-A, pp. 12-22a; 42 U.S.C. § 1396r-4.*

[63] *Ark. Admin. Code 016.06.20-212.40l(A); 016.06.41-213.0l0(A).*

[64] *State Plan Att. 4.19-A, pp. l, 9a; Att. 3.1-A, pp. la, laa.*

[65] *Ark. Admin. Code 016.06.41-201.000.*

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