NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-101 et. seq., and 25-10-129.

Effective July 1, 2020:

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) intends to revise the Arkansas Medicaid State Plan and Hospital Manual regarding Long Term Acute Care Hospitals (LTACs). The changes institute minimum requirements for LTACs to become separate licensed and certified entities eligible for enrollment in the Arkansas Medicaid Hospital Program.

Background: Arkansas Medicaid has six (6) LTACs enrolled within the state and co-located within acute care or general hospitals. These hospitals are very similar to other long-term care facilities serving Medicaid members. Arkansas Medicaid recognizes a very limited need for these hospitals’ specialized services. DHS seeks to implement State Plan and program rules that recognize these hospitals accordingly. The agency intends to limit the number of such hospitals to the six (6) LTACs already enrolled unless a needs assessment indicates an access to care issue.

Amendment and revisions: The rule revisions include the following. DHS revises the Arkansas Medicaid State Plan (pages 3.1-A page 1a; 3.1-A page 1 aa; 3.1-B page 2a; and 3.1-B page 2aa) to add the LTAC as its own designation with limitations on enrollment to current LTAC providers as of July 1, 2020, unless a needs assessment indicates an access to care issue exists necessitating reopening of enrollment. The plan amendment adds LTACs as providers for the medically needy and categorically needy and defines the amount, duration, and scope of services provided. DHS revises the Hospital Manual sections 201.000 and 201.100 to recognize LTACs as their own licensed and certified entity and to limit enrollment to those already enrolled as of July 1, 2020, unless a needs assessment indicates an access to care issue exists necessitating reopening of enrollment. Section 201.000 also adds LTACs as the fifth type of acute care hospital eligible for enrollment in the Arkansas Medicaid Hospital Program. Section 201.100 requires LTAC licensure by the Arkansas Department of Health and certification as an LTAC Title XVIII (Medicare) provider.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule on the Medicaid website at https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than May 11, 2020. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter’s name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6266.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin.

[Signature]
Janet Mann, Director
Division of Medical Services
1. Inpatient Hospital Services

All inpatient admissions to an acute care or general hospital, Long Term Acute Care Hospital (LTAC) or rehabilitative hospital will be allowed up to four (4) days of service per admission when determined inpatient care is medically necessary. Four (4) days of service per admission will be allowed when determined inpatient care is medically necessary for all inpatient admissions to:

- a. an acute care;
- b. general hospital;
- c. Long Term Acute Care Hospital (LTAC); or
- d. rehabilitative hospital.

On the fifth day of hospitalization, if the physician determines the patient should not be discharged on the fifth day of hospitalization, the hospital may contact the Quality Improvement Organization (QIO) and request an extension of inpatient days. The Quality Improvement Organization will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However, the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. Medically necessary inpatient days are available to individuals under age one (1) without regard to the four-day limit and extension procedures required under the plan. Additionally, effective for dates of service on or after November 1, 2001, a benefit limit of twenty-four (24) days per State Fiscal Year (July 1 through June 30) is imposed for recipients age twenty-one (21) and older in acute care or general hospitals or rehabilitative hospitals. No extensions will be authorized. The benefit limit does not apply to recipients receiving care in a Long Term Acute Care Hospital (LTAC) if the care has been prior authorized. The benefit limit does not apply to recipients under age twenty-one (21) in the Child Health Services (EPSDT) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program or beneficiaries, regardless of age, who meet the following criteria:

- Diagnosis, (one of the following):
  - the presence of two or more diagnoses on Axis I and/or Axis II is indicative of a serious emotional disorder;
  - the presence of a diagnosis on Axis I or Axis II and a diagnosis on Axis III;

- Poor prognostic factors are as evidenced by:
  - early age at time of onset;
  - positive family history for major mental illness;
  - prior treatment has been ineffective; treatment failure, poor response to treatment;
  - co-occurring presentation, such as (medical illness, developmental disability, substance abuse or substance abuse/disorder & and mental illness).
non-compliance with treatment; compromised social support system; or other evidence-based poor prognostic factors that (varies by condition or disorder).

Patient was referred by another behavioral health professional for an expert opinion.

Effective for dates of service on or after October 1, 2014, days over twenty-four (24) days per State Fiscal Year will be reimbursed for age twenty-one (21) and older.

Inpatient hospital services required for pancreas or kidney transplants, liver or bowel transplants, and skin transplants for burns are covered for eligible Medicaid recipients in the Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Refer to Attachment 3.1-E, Pages 2, 4 and 6.
1. Inpatient Hospital Services

A. Rehabilitative Hospital

1. Augmentative Communication Device (ACD) Evaluation - Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One Augmentative Communication Device (ACD) evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age twenty-one.

B. Long Term Acute Care Hospital (LTAC)

1. Long Term Acute Care Hospital (LTAC) provider enrollment is limited to those providers that were enrolled as of July 1, 2020, unless a needs assessment is performed and indicates an access to care issue exists and enrollment should be reopened.
1. Inpatient Hospital Services

All inpatient admissions to an acute care or general hospital, Long Term Acute Care Hospital (LTAC) or rehabilitative hospital will be allowed up to four (4) days of service per admission when determined inpatient care is medically necessary. Four (4) days of service per admission will be allowed when determined inpatient care is medically necessary for all inpatient admissions to:

   a. an acute care;
   b. general hospital;
   c. Long Term Acute Care Hospital (LTAC); or
   d. rehabilitative hospital.

On the fifth day of hospitalization, if the physician determines the patient should not be discharged on the fifth day of hospitalization, the hospital may contact the Quality Improvement Organization (QIO) and request an extension of inpatient days. The Quality Improvement Organization QIO will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However, the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. Medically necessary inpatient days are available to individuals under age one (1) without regard to the four-day limit and extension procedures required under the plan. Additionally, effective for dates of service on or after November 1, 2001, a benefit limit of twenty-four (24) days per State Fiscal Year (July 1 through June 30) is imposed for recipients age twenty-one (21) and older in acute care or general hospitals or rehabilitative hospitals. No extensions will be authorized. The 24-day limit does not apply to recipients receiving care in a Long Term Acute Care Hospital, LTAC if the care has been prior authorized. The benefit limit does not apply to recipients under age twenty-one (21) in the Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.
Effective for dates of service on or after October 1, 2014, days over twenty-four (24) days per State Fiscal Year will be reimbursed for age twenty-one (21) and older.

Inpatient hospital services required for pancreas or kidney transplants, liver or bowel transplants, and skin transplants for burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. Refer to Attachment 3.1-E, Pages 2, 4, and 6.
1. **Inpatient Hospital Services**

   **A. Rehabilitative Hospital**

   1. **Augmentative Communication Device (ACD) Evaluation** - Effective for dates of service on or after September 1, 1999. Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One (1) Augmentative Communication Device (ACD) evaluation may be performed every three (3) years based on medical necessity. The benefit limit may be extended for individuals under age twenty-one (21).

   **B. Long Term Acute Care Hospital (LTAC)**

   1. LTAC provider enrollment is limited to those providers that were enrolled as of July 1, 2020, unless a needs assessment is performed and indicates an access to care issue exists and enrollment should be reopened.
The Division of Health of the Arkansas Department of Health and Human Services licenses several types of hospitals, facilities, and institutions that may qualify for participation in the Arkansas Medicaid Program.

A. The Division Arkansas Department of Health licenses five (5) types of acute care hospitals that are eligible for enrollment in the Arkansas Medicaid Hospital Program. They are:

1. General hospitals;
2. Maternity and general medical care hospitals;
3. Maternity hospitals; and
4. Surgery and general medical care hospitals; and,
5. Long Term Acute Care (LTAC) hospitals. Provider enrollment is limited to those providers that were enrolled as LTACs as of July 1, 2020, unless a need assessment is performed that indicates an access to care issue exists and enrollment should be reopened.

B. The Arkansas Title XIX (Medicaid) State Plan employs the terms "acute care" and "acute care/general" interchangeably as general references to any of these five (5) types of hospitals, or their counterparts in other states, to avoid repeating the entire list each time that a reference is made to hospitals that are eligible for participation in the Arkansas Medicaid Hospital Program.

Following are the minimum requirements for participation in the Arkansas Medicaid Hospital Program:

A. An in-state hospital must be licensed by the Division Arkansas Department of Health of the Arkansas Department of Health and Human Services as an acute care/general hospital.

B. An out-of-state hospital must be licensed as an acute care/general hospital by the appropriate licensing agency within its home state.

C. A hospital must be certified as an acute care/general hospital Title XVIII (Medicare) provider.

D. Long Term Acute Care (LTAC) hospitals must be licensed as such by the Arkansas Department of Health and must also be certified as an LTAC Title XVIII (Medicare) provider.
MEMORANDUM

TO: Interested Persons and Providers
FROM: Janet Mann, Director, Division of Medical Services
DATE: April 10, 2020
SUBJ: Hospital Medicaid Provider Manual and SPA#2020-0006

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter’s name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments in writing, no later than May 11, 2020.