

2015 - 2017 REQUEST FOR SPECIAL LANGUAGE IN APPROPRIATION ACT

0710 DHS - Medical Services Division

ACT#: 254

SECTION#: 6

CURRENT SPECIAL LANGUAGE (WITH AGENCY REQUEST)

EXECUTIVE RECOMMENDATION

MEDICAID EXPANSION PROGRAM - PAYING ACCOUNTS. The Medicaid Expansion Program as established by Initiated Act 1 of 2000 shall be a separate and distinct component embracing (1) expanded Medicaid coverage and benefits to pregnant women; (2) expanded inpatient and outpatient hospital reimbursements and benefits to adults aged nineteen (19) to sixty-four (64); (3) expanded non-institutional coverage and benefits to adults aged 65 and over; and (4) creation and provision of a limited benefit package to adults aged nineteen (19) to sixty-four (64), to be administered by the Department of Human Services. Separate Paying Accounts shall be established for the Medicaid Expansion Program as designated by the Chief Fiscal Officer of the State, to be used exclusively for the purpose of drawing down federal funds associated with the federal share of expenditures and for the state share of expenditures transferred from the Medicaid Expansion Program Account or for any other appropriate state match funds.

The provisions of this section shall be in effect only from July 1, ~~2014~~ 2015 through June 30, ~~2015~~ 2016.

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ACCOUNTS. Such appropriations and fund accounts as may be necessary to administer the provisions of this act shall be established on the books of the Chief Fiscal Officer of the State, State Treasurer, and the Auditor of the State.

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POSITIONS. (a) Nothing in this act shall be construed as a commitment of the State of Arkansas or any of its agencies or institutions to continue funding any position paid from the proceeds of the Tobacco Settlement in the event that Tobacco Settlement funds are not sufficient to finance the position.

(b) State funds will not be used to replace Tobacco Settlement funds when such funds expire, unless appropriated by the General Assembly and authorized by the Governor.

(c) A disclosure of the language contained in (a) and (b) of this Section shall be made available to all new hire and current positions paid from the proceeds of the Tobacco Settlement by the Tobacco Settlement Commission.

(d) Whenever applicable the information contained in (a) and (b) of this Section shall be included in the employee handbook and/or Professional Services Contract paid from the proceeds of the Tobacco Settlement.

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TRANSFER RESTRICTIONS. The appropriations provided in this act shall not be transferred under the provisions of Arkansas Code 19-4-522, but only as provided by this act.

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TRANSFERS OF APPROPRIATIONS. In the event the amount of any of the budget classifications of maintenance and general operation in this act are found by the administrative head of the agency to be inadequate, then the agency head may request, upon forms provided for such purpose by the Chief Fiscal Officer of the State, a modification of the amounts of the budget classification. In that event, he shall set out on the forms the particular classifications for which he is requesting an increase or decrease, the amounts thereof, and his reasons therefor. In no event shall the total amount of the budget exceed either the amount of the appropriation or the amount of the funds available, nor shall any transfer be made from the capital outlay or data processing subclassifications unless specific authority for such transfers is provided by law, except for transfers from capital outlay to data processing when determined by the Department of Information Systems that data processing services for a state agency can be performed on a more cost-efficient basis by the Department of Information Systems than through the purchase of data processing equipment by that state agency. In considering the proposed modification as prepared and submitted by each state agency, the Chief Fiscal Officer of the State shall make such studies as he deems necessary. The Chief Fiscal Officer of the State shall, after obtaining the approval of the Legislative Council, approve the requested transfer if in his opinion it is in the best interest of the state.

Upon determination by the Director of the Department of Human Services that a Reallocation of Resources is necessary for the effective operation of the Medicaid Expansion Program Grants, the director, with the approval of

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the Governor, shall have the authority to request from the Chief Fiscal Officer of the State a transfer of Appropriation. This transfer authority applies only to Section 5 Medicaid Expansion Program Grants of this Act between Hospital and Medical Services Item (01) and Prescription Drugs Item (02). The limitation restrictions applicable to the Department Reallocation of Resources authority applies to this section.

The General Assembly has determined that the agency in this act could be operated more efficiently if some flexibility is given to that agency and that flexibility is being accomplished by providing authority to transfer between certain items of appropriation made by this act. Since the General Assembly has granted the agency broad powers under the transfer of appropriations, it is both necessary and appropriate that the General Assembly maintain oversight of the utilization of the transfers by requiring prior approval of the Legislative Council in the utilization of the transfer authority. Therefore, the requirement of approval by the Legislative Council is not a severable part of this section. If the requirement of approval by the Legislative Council is ruled unconstitutional by a court jurisdiction, this entire section is void.

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COMPLIANCE WITH OTHER LAWS. Disbursement of funds authorized by this act shall be limited to the appropriation for such agency and funds made available by law for the support of such appropriations; and the restrictions of the State Purchasing Law, the General Accounting and Budgetary Procedures Law, the Regular Salary Procedures and Restrictions Act, or their successors, and other fiscal control laws of this State, where applicable, and regulations promulgated by the Department of Finance and Administration, as authorized by law, shall be strictly complied with in disbursement of said funds.

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DEPARTMENT OF HUMAN SERVICES GRANTS FUND ACCOUNT. The Department of Human Services Grants Fund Account shall be used for the following grant programs to consist of general revenues and any other nonfederal funds, as may be appropriated by the General Assembly:

- (i) Children's Medical Services;
- (ii) Food Stamp Employment and Training Program;
- (iii) Aid to the Aged, Blind, and Disabled;
- (iv) Transitional Employment Assistance Program;
- (v) Private nursing home care;
- (vi) Infant Infirmary - nursing home care;
- (vii) Public Nursing Home Care;
- (viii) Prescription Drugs;
- (ix) Hospital and Medical Services;
- (x) Child and Family Life Institute;
- (xi) Community Services Block Grant;
- (xii) ARKIDSFIRST;
- (xiii) Child Health Management Services; and
- (xiv) Child Care Grant

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MEDICAL SERVICES - CHILD AND FAMILY LIFE INSTITUTE. The Child Health and Family Life Institute shall be administered under the direction of Arkansas Children's Hospital. Arkansas Children's Hospital shall enter into a cooperative agreement and/or contract with the University of Arkansas for Medical Sciences - Department of Pediatrics for services required in delivering the programs of the Child Health and Family Life Institute. Utilizing a multidisciplinary collaboration of professionals, the Child Health and Family Life Institute shall provide a statewide effort to explore, develop and evaluate new and better ways to address medically, socially and economically interrelated health and developmental needs of children with special health care needs and their families. The Child Health and Family Life Institute's priorities shall include, but are not limited to, wellness and prevention, screen and diagnosis, treatment and intervention, training and education and research and evaluation.

Arkansas Children's Hospital and the University of Arkansas for Medical Sciences - Department of Pediatrics shall make annual reports to the Arkansas Legislative Council on all matters of funding, existing programs and services offered through the Child Health and Family Life Institute.

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MEDICAL SERVICES - PHARMACEUTICAL DISPENSING FEE SURVEY. No more than two years prior to making any changes to the current pharmaceutical dispensing fee, the State shall conduct an independent survey utilizing generally accepted accounting principles, to determine the cost of dispensing a prescription by pharmacists in Arkansas. Only factors relative to the cost of dispensing shall be surveyed. These factors shall not include actual acquisition costs or average profit or any combination of actual acquisition costs or average profit. The survey results shall be the basis for establishing the dispensing fee paid to participating pharmacies in the Medicaid prescription drug program in accordance with Federal requirements. The dispensing fee shall be no lower than the cost of dispensing as determined by the survey. Nothing in this section shall be construed to prohibit the State from increasing the dispensing fee at any time.

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MEDICAL SERVICES - GENERAL MEDICAID RATE METHODOLOGY PROVISIONS.

AGENCY REQUEST

(a) Rates established by the Division of Medical Services for the services or programs covered by this Act shall be calculated by the methodologies approved by the Centers for Medicare and Medicaid Services (CMS). The Division of Medical Services shall have the authority to reduce or increase rates based on the approved methodology. Further, the Division of Medical Services shall have the authority to increase or decrease rates for good cause including, but not limited to: (1) Identification of provider(s) who can render needed services of equal quality at rates less than traditionally charged and who meet the applicable federal and state laws, rules and regulations pertaining to the provision of a particular service;

(2) Identification that a provider or group of providers has consistently charged rates to the Arkansas Medicaid Program greater than to other purchasers of medical services of similar size;

(3) The Division determines that there has been significant changes in the technology or process by which services are provided by a provider or group of providers which has affected the costs of providing services, or;

(4) A severe economic downturn in the Arkansas economy which has affected the overall state budget of the Division of Medical Services.

The Division of Medical Services shall make available to requesting providers, the CMS's inflationary forecasts (CMS Market Basket Index). Rates established with cost of living increases based on the CMS Market Basket Index or other indices will be adjusted annually except when the state budget does not provide sufficient appropriation and funding to affect

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the change or portion thereof.

(b) Any rate methodology changes proposed by the Division of Medical Services both of a general and specific nature, shall be subject to prior approval by the Legislative Council or Joint Budget Committee.

Determining the maximum number of employees and the maximum amount of appropriation and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly. This is usually accomplished by delineating such maximums in the appropriation act(s) for a state agency and the general revenue allocations authorized for each fund and fund account by amendment to the Revenue Stabilization law. Further, the General Assembly has determined that the Department of Human Services - Division of Medical Services may operate more efficiently if some flexibility is provided to the Department of Human Services - Division of Medical Services authorizing broad powers under this section. Therefore, it is both necessary and appropriate that the General Assembly maintain oversight by requiring prior approval of the Legislative Council or Joint Budget Committee as provided by this section. The requirement of approval by the Legislative Council or Joint Budget Committee is not a severable part of this section. If the requirement of approval by the Legislative Council or Joint Budget Committee is ruled unconstitutional by a court of competent jurisdiction, this entire section is void.

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<p>FUND USAGE AUTHORIZED. The Arkansas Children's Hospital may request the Department of Human Services - Division of Medical Services to retain in the Department of Human Services Grant Fund account an amount not to exceed \$2,100,000 from funds made available by this Act for the Child and Family Life Institute, Section 4, item number 06 to be used to match federal funds used for supplemental Medicaid payments to Arkansas Children's Hospital. These retained funds shall not be recovered to transfer to the General Revenue Allotment Reserve Fund.</p>	<p>AGENCY REQUEST</p>

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STATE PLAN. The State Plan must include the provision of EPSDT services as those services are defined in §1396d(r). See §§ 1396a(a)(10)(A), 1396d(a)(4)(B); see also 1396a(a)(43). Section 1396d(r) lists in detail the screening services, vision services, dental services, and hearing services that the State Plan must expressly include, but with regard to treatment services, it states that EPSDT means "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5) (emphasis added). Reading §1396a, § 1396d(a), and § 1396d(r) together, we believe that the State Plan need not specifically list every treatment service conceivably available under the EPSDT mandate.

The State Plan, however, must pay part or all of the cost of treatments to ameliorate conditions discovered by the screening process when those treatments meet the definitions set forth in § 1396a. See §1396d(r)(5); see also §§1396a(a)(10), 1396a (a)(43), and 1396d(a)(4)(B). The Arkansas State Plan states that the "State will provide other health care described in [42 U.S.C. 1396d(a)] that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, even when such health care is not otherwise covered under the State Plan." See State Plan Under Title XIX of the Social Security Act Medical Assistance Program, State Of Arkansas at § 4.b. This provision Meets the EPSDT mandate of the Medicaid Act.

We affirm the district court's decision to the extent that it holds that a

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Medicaid-Eligible individual has a federal right to early intervention day treatment when a physician recommends such treatment. Section 1396d(r) (5) states that EPSDT includes any treatments or measures outlined in § 1396d(a). There are twenty-seven sub-parts to §1396d(a), and we find that sub-part (a)(13), in particular, when read with the other sections of the Medicaid Act listed above, mandates that early intervention day treatment be provided when it is prescribed by a physician. See 42 U.S.C. §1396d(a) (13) (defining medical assistance reimbursable by Medicaid as "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician...for the maximum reduction of physical and mental disability and restoration of an individual to the best possible functional level"). Therefore, after CHMS clinic staff perform a diagnostic evaluation of an eligible child, if the CHMS physician prescribes early intervention day treatment as a service that would lead to the maximum reduction of medical and physical disabilities and restoration of the child to his or her best possible functional level, the Arkansas State Plan must reimburse the treatment. Because CHMS clinics are the only providers of early intervention day treatment, Arkansas must reimburse those clinics.

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EXECUTIVE RECOMMENDATION

MEDICAL SERVICES - STATE MEDICAID PROGRAM/PERSONAL CARE PROGRAM.

AGENCY REQUEST

(a) It is the legislative intent that the Department of Human Services in its administration of the Arkansas Medicaid Program set forth Medicaid provider participation requirements for "personal care providers" that will insure sufficient available providers to meet the required needs of all eligible recipients, to include insuring available in home services twenty-four (24) hours a day and seven (7) days a week for personal care.

(b) For the purposes of this section, "private care agencies" are defined as those providers licensed by the Department of Labor, certified as ElderChoices Providers and who furnish in home staffing services for respite, chore services, and homemaker services, and are covered by liability insurance of not less than one million dollars (\$1,000,000) covering their employees and independent contractors while they are engaged in providing services, such as personal care, respite, chore services, and homemaker services.

(c) The purpose of this section is to allow the private care agencies defined herein to be eligible to provide Medicaid reimbursed personal care services seven (7) days a week, and does not supercede Department of Human Services rules establishing monthly benefit limits and prior authorization requirements.

(d) The availability of providers shall not require the Department of Human Services to reimburse for twenty-four (24) hours per day of personal care services.

(e) The Arkansas Department of Human Services, Medical Services

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Division shall take such action as required by the Centers for Medicare and Medicaid Services to amend the Arkansas Medicaid manual to include, private care agencies, as qualified entities to provide Medicaid reimbursed personal care services.

(f) The private care agencies shall comply with rules and regulations promulgated by the Arkansas Department of Health which shall establish a separate licensure category for the private care agencies for the provision of Medicaid reimbursable personal care services seven (7) days a week.

(g) The Arkansas Department of Health shall supervise the conduct of the personal care agencies defined herein.

(h) The purpose of this section is to insure the care provided by the private care agencies, is consistent with the rules and regulations of the Arkansas Department of Health.

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REVIEW OF RULES IMPACTING STATE MEDICAID COSTS. (a) In light of the rapidly rising potential costs to the State attributable to the Medicaid program and the importance of Medicaid expenditures to the health and welfare of the citizens of this State, the General Assembly finds it desirable to exercise more thorough review of future proposed changes to rules that might impact those costs or expenditures.

(b) As used in this section, "rule impacting state Medicaid costs" means a proposed rule, as defined by § 25-15-202(8), or a proposed amendment to an existing rule, as defined by § 25-15-202(8), that would, if adopted, adjust Medicaid reimbursement rates, Medicaid eligibility criteria, or Medicaid benefits, including without limitation a proposed rule or a proposed amendment to an existing rule seeking to accomplish the following:

- (1) Reduce the number of individuals covered by Arkansas Medicaid;
- (2) Limit the types of services covered by Arkansas Medicaid;
- (3) Reduce the utilization of services covered by Arkansas Medicaid;
- (4) Reduce provider reimbursement;
- (5) Increase consumer cost-sharing;
- (6) Reduce the cost of administering Arkansas Medicaid;
- (7) Increase Arkansas Medicaid revenues;
- (8) Reduce fraud and abuse in the Arkansas Medicaid program;
- (9) Change any of the methodologies used for reimbursement of providers;
- (10) Seek a new waiver or modification of an existing waiver of any provision under Medicaid, Title XIX, of the Social Security Act, including a

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waiver that would allow a demonstration project;

(11) Participate or seek to participate in Social Security Act Section 1115(a)(1) waiver authority that would allow operation of a demonstration project or program;

(12) Participate or seek to participate in a Social Security Act Section 1115(a)(2) request for the Secretary of the Department of Health and Human Services to provide federal financial participation for costs associated with a demonstration project or program;

(13) Implement managed care provisions under Section 1932 of Medicaid, Title XIX of the Social Security Act; or

(14) Participate or seek to participate in the Centers for Medicare and Medicaid Services Innovation projects or programs.

(c)(1) In addition to filing requirements under the Arkansas Administrative Procedure Act, § 25-15-201 et seq., and § 10-3-309, the Department of Human Services shall, at least thirty (30) days before the expiration of the period for public comment, file a proposed rule impacting state Medicaid costs or a proposed amendment to an existing rule impacting state Medicaid costs with the Senate Interim Committee on Public Health, Welfare, and Labor and the House Interim Committee on Public Health, Welfare, and Labor, or, when the General Assembly is in session, with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare and Labor.

(2) Any review of the proposed rule or proposed amendment to an existing rule by the Senate and House Interim Committees on Public Health, Welfare and Labor or the Senate and House Committees on Public Health,

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Welfare, and Labor shall occur within forty-five (45) days of the date the proposed rule or proposed amendment to an existing rule is filed with the committees.

(d)(1) If adopting an emergency rule impacting state Medicaid costs, in addition to the filing requirements under the Arkansas Administrative Procedure Act, § 25-15-201 et seq. and § 10-3-309, the Department of Human Services shall notify the Speaker of the House of Representatives, the President Pro Tempore of the Senate, the chair of the Senate Committee on Public Health, Welfare, and Labor, and the chair of the House Committee on Public Health, Welfare and Labor of the emergency rule and provide each of them a copy of the rule within five (5) business days of adopting the rule.

(2) Any review of the emergency rule by the Senate and House Interim Committees on Public Health, Welfare and Labor or the Senate and House Committees on Public Health, Welfare, and Labor shall occur within forty-five (45) days of the date the emergency rule is provided to the chairs.

(e)(1) The Joint Budget Committee may review a rule impacting state Medicaid costs during a regular, fiscal, or special session of the General Assembly.

(2) Actions taken by the Joint Budget Committee when reviewing a rule impacting state Medicaid costs shall have the same effect as actions taken by the Legislative Council under § 10-3-309.

(3) If the Joint Budget Committee reviews a rule impacting state Medicaid costs, it shall file a report of its actions with the Legislative

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Council as soon as practicable.

(f) This section expires on June 30, ~~2015~~ 2016.

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(a) As used in this section, "Health Care Independence Program" means the Health Care Independence Program established under the Health Care Independence Act of 2013, Arkansas Code § 20-77-2401 et seq.

(b)(1) Determining the maximum number of employees, the maximum amount of appropriation, for what purposes an appropriation is authorized, and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly.

(2) The purposes of subdivision (b)(1) of this section are typically accomplished by:

(A) Identifying the purpose in the appropriation act;

(B) Delineating such maximums in the appropriation act for a state agency; and

(C) Delineating the general revenue allocations authorized for each fund and fund account by amendment to the Revenue Stabilization Law, Arkansas Code § 19-5-101 et seq.

(3) It is both necessary and appropriate that the General Assembly restrict the use of appropriations authorized in this act.

(c)(1) Except as provided in this subsection, the Department of Human Services shall not allocate, budget, expend, or utilize any appropriation authorized by the General Assembly for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or the Health Care Independence Program, including without limitation:

(A) Unsolicited communications mailed to potential recipients;

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(B) Television, radio, or online commercials;
(C) Billboard or mobile billboard advertising;
(D) Advertisements printed in newspapers, magazines, or other print media; and
(E) Internet websites and electronic media.

(2) This subsection does not prohibit the department from:

(A) Direct communications with:
(i) Licensed insurance agents; and
(ii) Persons licensed by the department;

(B) Solicited communications with potential recipients;

(C)(i) Responding to an inquiry regarding the coverage for which a potential recipient might be eligible, including without limitation providing educational materials or information regarding any coverage for which the individual might qualify.

(ii) Educational materials and information distributed under subdivision (c)(2)(C)(i) of this section shall contain only factual information and shall not contain subjective statements regarding the coverage for which the potential recipient might be eligible; and

(D) Using an Internet website for the exclusive purpose of enrolling individuals in the Arkansas Health Insurance Marketplace or the Health Care Independence Program.

(d) The Department of Human Services shall not apply for or accept any funds, including without limitation federal funds, for the purpose of

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advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or the Health Care Independence Program.

(e)(1) Except as provided in subdivision (e)(2) of this section, the Department of Human Services shall not:

(A)(i) Except as provided in subdivision (e)(1)(A)(ii) of this section, allocate, budget, expend, or utilize an appropriation authorized by the General Assembly for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

(ii) Subdivision (e)(1)(A)(i) of this section does not apply to regulatory and training responsibilities related to navigators, guides, certified application counselors, and certified licensed producers; and

(B) Apply for or accept any funds, including without limitation federal funds, for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

(2) Subdivision (e)(1) of this section does not apply to certified application counselors at health related institutions, including without limitation the University of Arkansas for Medical Sciences.

(f) An appropriation authorized by the General Assembly shall not

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be subject to the provisions allowed through reallocation of resources or transfer of appropriation authority for the purpose of transferring an appropriation to any other appropriation authorized for the Department of Human Services to be allocated, budgeted, expended, or utilized in a manner prohibited by this section.

(g) The provisions of this section are severable, and the invalidity of any subsection or subdivision of this section shall not affect other provisions of the section that can be given effect without the invalid provision.

(h) This section expires on June 30, ~~2015~~ 2016.

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(a) As used in this section, "Health Care Independence Program" means the Health Care Independence Program established under the Health Care Independence Act of 2013, Arkansas Code § 20-77-2401 et seq.

(b)(1) Determining the maximum number of employees, the maximum amount of appropriation, for what purposes an appropriation is authorized, and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly.

(2) The purposes of subdivision (b)(1) of this section are typically accomplished by:

- (A) Identifying the purpose in the appropriation act;
- (B) Delineating such maximums in the appropriation act for a state agency; and
- (C) Delineating the general revenue allocations

authorized for each fund and fund account by amendment to the Revenue Stabilization Law, Arkansas Code § 19-5-101 et seq.

(3) It is both necessary and appropriate that the General Assembly restrict the use of appropriations authorized in this act.

(c)(1) The Department of Human Services shall submit and seek approval of a state plan amendment or waiver, or both, for the following revisions to the Health Care Independence Program to be effective no later than February 1, 2015:

(A) Approval of a limited state-designed nonemergency transportation benefit for persons covered under the Health Care Independence Program;

(B) Approval of a model to allow non-aged, nondisabled persons eligible to participate in the Health Care Independence

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Program to enroll in a program that will create and utilize independence accounts that operate similarly to a health savings account or medical savings account; and

(C) That cost sharing under the Health Care Independence Program shall apply to beneficiaries with incomes above fifty percent (50%) of the federal poverty level.

(2) The Department of Human Services shall:

(A) Submit drafts of state plan amendments or waivers required under subdivision (c)(1) of this section for public comment by August 1, 2014; and

(B) File the required state plan amendments or waivers with the United States Department of Health and Human Services by September 15, 2014.

(d)(1) Except as provided in subdivision (d)(2) of this section, if the Department of Human Services is unable to secure the approvals requested under subsection (c) of this section, then effective for dates of service on and after February 1, 2015, the Department of Human Services shall not allocate, budget, expend, or utilize appropriations under this act for the participation of persons in the Health Care Independence Program.

(2) Subdivision (d)(1) of this section does not prohibit the payment of expenses incurred before February 1, 2015, by persons participating in the Health Care Independence Program who were determined to be more effectively covered through the standard Medicaid program.

(e) This section expires on June 30, ~~2015~~ 2016.

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EXECUTIVE RECOMMENDATION

MEDICAID PRIMARY CARE CASE MANAGEMENT PROGRAM.

AGENCY REQUEST

(a) The General Assembly finds that:

(1) The Arkansas Delta is an area that is medically underserved and has some of the worst health outcomes in our state, with a large number of recipients who are in the top quartile of costs;

(2)(A) There has been much success in other states, particularly in the Louisiana Delta with improvements in health outcomes and saving money through the use of an intensive care-coordination, shared-savings model of care.

(B) This success has come through contracting with private companies that specialize in working with those individuals who meet certain criteria and are at a minimum in the top quartile of costs to the Medicaid program;

(3) Medicaid is one of the largest percentage expenditures of Arkansas tax dollars, and there is a need for reforming approaches to the use of these dollars; and

(4) The approach created in this section to dealing with this population has never been implemented in Arkansas.

(b)(1)(A) The Department of Human Services shall contract with an experienced vendor to implement a two-year Medicaid Primary Care Case Management shared-savings pilot program in the Arkansas Delta region to begin January 1, 2014.

(B) The department shall give preference to a vendor that:

(i) Demonstrates experience with the type of model established under this section in the type of geographic area specified

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insubsection (e) of this section;

(ii) Has demonstrated customer satisfaction as documented through independent Consumer Assessment of Healthcare Providers and Systems survey; and

(iii) Maintains a Utilization Review Accreditation Commission accreditation for its Health Utilization Management and Case Management programs.

(2) The pilot program shall encompass a minimum of five thousand (5,000) recipients who:

(A) Are not currently in the Arkansas Patient-Centered Medical Home Program, the federal Comprehensive Primary Care Initiative, or a similar home health program;

(B)(i) Have catastrophic or chronic conditions as defined by the Johns Hopkins Adjusted Clinical Groups System; or

(ii) Are women with a history of past high-risk pregnancies, poor birth outcomes or pre-term deliveries; and

(C) Whose estimated costs are in the top quartile for their defined population.

(c) The vendor shall recruit an adequate number of primary care clinics to initiate the program.

(d) The Medicaid Primary Care Case Management shared savings pilot program shall exclude the Alternatives for Persons with Disabilities, the Division of Developmental Disabilities Services Alternative Community Services, Elder Choices, Living Choices Assisted Living waivers, and members of the Program of All-Inclusive Care for the Elderly.

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(e) The Medicaid Primary Care Case Management program shared savings pilot program shall include without limitation the following Arkansas delta counties:

- (1) Arkansas;
- (2) Ashley;
- (3) Baxter;
- (4) Bradley;
- (5) Calhoun;
- (6) Chicot;
- (7) Clay;
- (8) Cleveland;
- (9) Crittenden;
- (10) Cross;
- (11) Dallas;
- (12) Desha;
- (13) Drew;
- (14) Fulton;
- (15) Grant;
- (16) Greene;
- (17) Independence;
- (18) Izard;
- (19) Jackson;
- (20) Jefferson;
- (21) Lawrence;
- (22) Lee;

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- (23) Lincoln;
- (24) Lonoke;
- (25) Marion;
- (26) Mississippi;
- (27) Monroe;
- (28) Ouachita;
- (29) Phillips;
- (30) Poinsett;
- (31) Prairie;
- (32) Randolph;
- (33) Searcy;
- (34) Sharp;
- (35) St. Francis;
- (36) Stone;
- (37) Union;
- (38) Van Buren; and
- (39) Woodruff.

(f) The department shall require that a contracting vendor generate savings in comparison to a risk-adjusted Arkansas Fee-For-Service benchmark.

(g) The per-member monthly fee paid to the vendor shall not decrease the current primary care case management fee paid to the primary care providers.

(h)(1) Savings realized under the Medicaid Primary Care Case Management program shall be shared:

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(A) Thirty-four percent (34%) with the department;
and

(B)(i) Sixty-six percent (66%) with the Medicaid Primary Care Case Management shared-savings pilot program vendor up to a maximum sharing cap of five percent (5%) of the total cost of administrative and health service expenditures as defined by the Centers for Medicare and Medicaid Service.

(ii) Further, fifty percent (50%) of savings received by the vendor shall be shared with eligible contracted network primary care providers based upon meeting agreed upon performance standards.

(2) Twenty five percent (25%) of the Medicaid Primary Care Case Management shared-savings pilot program vendor's administrative per member per month fee shall be at risk and shall be paid back to the state if savings are not realized.

(i)(1) After the Medicaid Primary Care Case Management shared savings pilot program has operated for fifteen (15) months, the department shall utilize an agreed upon savings algorithm to calculate savings based on the first twelve (12) months of operations, allowing three (3) months of run-out.

(2)(A) Savings shall be disbursed within thirty (30) calendar days of final calculation.

(B) After the initial year of operation, savings shall be calculated on a quarterly basis.

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(j) This section does not conflict with or reduce the Medicaid hospital access payments under section § 20-77-1901 et seq.

(k)(1) This section does not require a physician to participate in the pilot program created under this section.

(2) A physician has the right to refuse to contract under the pilot program created under this section or to terminate the contract at any time without penalty.

(l) If requested, the vendor shall agree to support any contracted physician in meeting the requirements of the Arkansas Patient-Centered Medicaid Home model.

The provisions of this section shall be in effect only from July 1, 2015 through June 30, 2016.