Stricken language would be deleted from and underlined language would be added to present law.

State of Arkansas *As Engrossed: H4/1/13 H4/6/13 H4/10/13*
89th General Assembly
Regular Session, 2013

A Bill

HOUSE BILL 1219

By: Joint Budget Committee

For An Act To Be Entitled

AN ACT TO MAKE AN APPROPRIATION FOR PERSONAL SERVICES AND OPERATING EXPENSES FOR THE DEPARTMENT OF HUMAN SERVICES - DIVISION OF MEDICAL SERVICES FOR THE FISCAL YEAR ENDING JUNE 30, 2014; AND FOR OTHER PURPOSES.

Subtitle

AN ACT FOR THE DEPARTMENT OF HUMAN SERVICES - DIVISION OF MEDICAL SERVICES APPROPRIATION FOR THE 2013-2014 FISCAL YEAR.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. REGULAR SALARIES - OPERATIONS. There is hereby established for the Department of Human Services - Division of Medical Services for the 2013-2014 fiscal year, the following maximum number of regular employees.

Item No.	Class Code	Title	Maximum No. of Employees	Maximum Annual Salary Rate Fiscal Year 2013-2014
(1)	L008N	PHYSICIAN SPECIALIST	2	GRADE N917
(2)	N181N	DIRECTOR OF MEDICAL SERVICES	1	GRADE N915
(3)	L016N	REGISTERED PHARMACIST	6	GRADE N911
(4)	N080N	DHS/DMS ASSISTANT DIRECTOR - FISCAL	2	GRADE N907
(5)	N099N	DHS/DMS ADD - LONG TERM CARE	1	GRADE N906

(6)	N100N	DHS/DMS ADD - MEDICAL SERVICES	2	GRADE N906
(7)	N110N	DHS ASST DIR CONTRACT MONITORING UNIT	1	GRADE N905
(8)	A010C	AGENCY CONTROLLER II	1	GRADE C128
(9)	D007C	INFORMATION SYSTEMS MANAGER	2	GRADE C128
(10)	A016C	DHS DMS BUSINESS OPERATIONS MANAGER	*8*	GRADE C127
(11)	L003C	PSYCHOLOGIST	4	GRADE C127
(12)	L010C	DHS DMS MEDICAL ASSISTANCE MANAGER	*8*	GRADE C125
(13)	L009C	NURSE MANAGER	*4*	GRADE C125
(14)	A031C	ASSISTANT CONTROLLER	1	GRADE C124
(15)	L015C	CLINICAL SPEECH PATHOLOGIST	2	GRADE C124
(16)	B023C	ENGINEER, P.E.	1	GRADE C124
(17)	L021C	NURSING HOME ASSISTANT ADMINISTRATOR	1	GRADE C123
(18)	L020C	NURSING SERVICES UNIT MANAGER	2	GRADE C123
(19)	L019C	REGISTERED NURSE COORDINATOR	5	GRADE C123
(20)	A044C	AUDIT COORDINATOR	3	GRADE C122
(21)	G099C	DHS PROGRAM ADMINISTRATOR	*13*	GRADE C122
(22)	L027C	REGISTERED NURSE SUPERVISOR	*11*	GRADE C122
(23)	A052C	ACCOUNTING COORDINATOR	1	GRADE C121
(24)	A050C	AGENCY FISCAL MANAGER	1	GRADE C121
(25)	M011C	FAMILY SERVICE WORKER COUNTY SUP	1	GRADE C121
(26)	A047C	FINANCIAL ANALYST II	1	GRADE C121
(*27*)	A056C	DHS FINANCIAL SECTION MANAGER	2	GRADE C120
(*28*)	L040C	DIETARY SERVICES DIRECTOR	1	GRADE C120
(*29*)	L038C	REGISTERED NURSE	*68*	GRADE C120
(*30*)	E023C	TRAINING PROJECT MANAGER	1	GRADE C120
(*31*)	D063C	COMPUTER SUPPORT SPECIALIST	2	GRADE C119
(*32*)	D062C	DATABASE ANALYST	1	GRADE C119
(*33*)	G152C	DHS PROGRAM MANAGER	*14*	GRADE C119
(*34*)	G147C	GRANTS COORDINATOR	2	GRADE C119
(*35*)	X067C	HEALTH FACILITIES SURVEYOR	21	GRADE C119
(*36*)	D061C	INFORMATION SYSTEMS COORD SPECIALIST	1	GRADE C119
(*37*)	X062C	QUALITY ASSURANCE COORDINATOR	2	GRADE C119
(*38*)	A060C	SENIOR AUDITOR	*10*	GRADE C119
(*39*)	A075C	FINANCIAL ANALYST I	1	GRADE C118
(*40*)	A081C	AUDITOR	*2*	GRADE C117
(*41*)	R027C	BUDGET SPECIALIST	2	GRADE C117

(*42*)	G183C	DHS PROGRAM COORDINATOR	*10*	GRADE C117
(*43*)	L055C	DIETICIAN	1	GRADE C117
(*44*)	D068C	INFORMATION SYSTEMS ANALYST	2	GRADE C117
(*45*)	D067C	INFORMATION SYSTEMS SECURITY ANALYST	2	GRADE C117
(*46*)	G179C	LEGAL SERVICES SPECIALIST	1	GRADE C117
(*47*)	M039C	MEDICAID SERVICES SUPERVISOR	2	GRADE C117
(*48*)	G178C	POLICY DEVELOPMENT COORDINATOR	3	GRADE C117
(*49*)	B076C	RESEARCH PROJECT ANALYST	1	GRADE C117
(*50*)	A089C	ACCOUNTANT I	1	GRADE C116
(*51*)	A088C	ASSETS COORDINATOR	1	GRADE C116
(*52*)	X124C	HEALTH FACILITY REVIEWER	1	GRADE C116
(*53*)	C037C	ADMINISTRATIVE ANALYST	7	GRADE C115
(*54*)	A091C	FISCAL SUPPORT ANALYST	3	GRADE C115
(*55*)	C050C	ADMINISTRATIVE SUPPORT SUPERVISOR	1	GRADE C113
(*56*)	L070C	HEALTH CARE ANALYST	*18*	GRADE C113
(*57*)	C056C	ADMINISTRATIVE SPECIALIST III	28	GRADE C112
(*58*)	A098C	FISCAL SUPPORT SPECIALIST	2	GRADE C112
(*59*)	A101C	ACCOUNTING TECHNICIAN	1	GRADE C109
(*60*)	C073C	ADMINISTRATIVE SPECIALIST II	*12*	GRADE C109
(*61*)	C087C	ADMINISTRATIVE SPECIALIST I	10	GRADE C106
	MAX. NO. OF EMPLOYEES		*322*	

SECTION 2. REGULAR SALARIES - OFFICE OF MEDICAID INSPECTOR GENERAL. There is hereby established for the Department of Human Services - Division of Medical Services - Office of Medicaid Inspector General for the 2013-2014 fiscal year, the following maximum number of regular employees.

Item No.	*Class Code*	*Title*	*Maximum No. of Employees*	*Maximum Annual Salary Rate Fiscal Year 2013-2014*
(1)		*MEDICAID INSPECTOR GENERAL*	*1*	*$150,000*
(2)		*INSPECTOR GENERAL CHIEF COUNSEL*	*1*	*$120,000*
(3)	*A016C*	*DHS DMS BUSINESS OPERATIONS MANAGER*	*1*	*GRADE C127*
(4)	*L010C*	*DHS DMS MEDICAL ASSISTANCE MANAGER*	*1*	*GRADE C125*
(5)		*MEDICAID FRAUD INVESTIGATOR*	*2*	*GRADE C125*

(6)	*L009C NURSE MANAGER*	*1*	*GRADE C125*
(7)	*G099C DHS PROGRAM ADMINISTRATOR*	*2*	*GRADE C122*
(8)	*L027C REGISTERED NURSE SUPERVISOR*	*3*	*GRADE C122*
(9)	*M009C LICENSED CERTIFIED SOCIAL WORKER*	*1*	*GRADE C121*
(10)	*L038C REGISTERED NURSE*	*3*	*GRADE C120*
(11)	*G152C DHS PROGRAM MANAGER*	*1*	*GRADE C119*
(12)	*A060C SENIOR AUDITOR*	*4*	*GRADE C119*
(13)	*A081C AUDITOR*	*2*	*GRADE C117*
(14)	*G183C DHS PROGRAM COORDINATOR*	*1*	*GRADE C117*
(15)	*C013C MEDICAL SERVICES REPRESENTATIVE*	*4*	*GRADE C117*
(16)	*A084C PROGRAM/FIELD AUDIT SPECIALIST*	*3*	*GRADE C116*
(17)	*G210C DHS PROGRAM SPECIALIST*	*1*	*GRADE C115*
(18)	*L070C HEALTH CARE ANALYST*	*1*	*GRADE C113*
(19)	*C073C ADMINISTRATIVE SPECIALIST II*	*2*	*GRADE C109*
	MAX. NO. OF EMPLOYEES	*35*	

SECTION *3*. EXTRA HELP - OPERATIONS. There is hereby authorized, for the Department of Human Services - Division of Medical Services for the 2013-2014 fiscal year, the following maximum number of part-time or temporary employees, to be known as "Extra Help", payable from funds appropriated herein for such purposes: seven (7) temporary or part-time employees, when needed, at rates of pay not to exceed those provided in the Uniform Classification and Compensation Act, or its successor, or this act for the appropriate classification.

SECTION 4. EXTRA HELP - OFFICE OF MEDICAID INSPECTOR GENERAL. There is hereby authorized, for the Department of Human Services - Division of Medical Services - Office of Medicaid Inspector General for the 2013-2014 fiscal year, the following maximum number of part-time or temporary employees, to be known as "Extra Help", payable from funds appropriated herein for such purposes: two (2) temporary or part-time employees, when needed, at rates of pay not to exceed those provided in the Uniform Classification and Compensation Act, or its successor, or this act for the appropriate classification.

SECTION *5*. APPROPRIATION - OPERATIONS. There is hereby appropriated,

to the Department of Human Services - Division of Medical Services, to be payable from the paying account as determined by the Chief Fiscal Officer of the State, for personal services and operating expenses of the Department of Human Services - Division of Medical Services - Operations for the fiscal year ending June 30, 2014, the following:

ITEM NO.		FISCAL YEAR 2013-2014
(01)	REGULAR SALARIES	*$16,178,191*
(02)	EXTRA HELP	201,892
(03)	PERSONAL SERVICES MATCHING	*5,441,071*
(04)	OVERTIME	5,000
(05)	MAINT. & GEN. OPERATION	
	(A) OPER. EXPENSE	*3,541,565*
	(B) CONF. & TRAVEL	*233,728*
	(C) PROF. FEES	555,132
	(D) CAP. OUTLAY	*144,388*
	(E) DATA PROC.	0
(06)	DATA PROCESSING SERVICES	299,600
	TOTAL AMOUNT APPROPRIATED	*$26,600,567*

SECTION 6. APPROPRIATION - OFFICE OF MEDICAID INSPECTOR GENERAL. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the paying account as determined by the Chief Fiscal Officer of the State, for personal services and operating expenses of the Department of Human Services - Division of Medical Services - Office of Medicaid Inspector General for the fiscal year ending June 30, 2014, the following:

ITEM NO.		*FISCAL YEAR 2013-2014*
(01)	*REGULAR SALARIES*	*$1,345,580*
(02)	*EXTRA HELP*	*151,234*
(03)	*PERSONAL SERVICES MATCHING*	*376,763*
(04)	*MAINT. & GEN. OPERATION*	
	(A) OPER. EXPENSE	*76,542*

(B) CONF. & TRAVEL	*12,612*
(C) PROF. FEES	*0*
(D) CAP. OUTLAY	*5,612*
(E) DATA PROC.	*0*
TOTAL AMOUNT APPROPRIATED	*$1,968,343*

SECTION *7*. APPROPRIATION - GRANTS. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the paying account as determined by the Chief Fiscal Officer of the State, for grant payments of the Department of Human Services - Division of Medical Services - Grants for the fiscal year ending June 30, 2014, the following:

ITEM NO.		FISCAL YEAR 2013-2014
(01)	PRIVATE NURSING HOME CARE	$687,787,762
(02)	INFANT INFIRMARY	26,733,146
(03)	PUBLIC NURSING HOME CARE	212,598,210
(04)	PRESCRIPTION DRUGS	373,142,423
(05)	HOSPITAL AND MEDICAL SERVICES	3,905,842,951
(06)	CHILD AND FAMILY LIFE INSTITUTE	2,100,000
(07)	ARKIDS B PROGRAM	137,336,792
	TOTAL AMOUNT APPROPRIATED	$5,345,541,284

SECTION *8*. APPROPRIATION - NURSING HOME CLOSURE COSTS. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the Long-Term Care Trust Fund, for the payment of relocation costs of residents in long-term care facilities, maintenance and operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost for the fiscal year ending June 30, 2014, the following:

ITEM NO.		FISCAL YEAR 2013-2014
(01)	EXPENSES	$50,000

SECTION *9*. APPROPRIATION - LONG-TERM CARE FACILITY RECEIVERSHIP. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the Long Term Care Facility Receivership Fund Account, for the payment of expenses of long-term care facility receivers as authorized by law of the Department of Human Services - Division of Medical Services - Long-Term Care Facility Receivership for the fiscal year ending June 30, 2014, the following:

ITEM NO.		FISCAL YEAR 2013-2014
(01)	EXPENSES	$100,000

SECTION *10*. APPROPRIATION - NURSING HOME QUALITY GRANTS. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the Long-Term Care Trust Fund, for Nursing Home Quality Grants of the Department of Human Services - Division of Medical Services - Nursing Home Quality Grants for the fiscal year ending June 30, 2014, the following:

ITEM NO.		FISCAL YEAR 2013-2014
(01)	NURSING HOME QUALITY GRANTS AND AID	$1,500,000

SECTION *11*. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. 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

SECTION *12*. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. 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.

The provisions of this section shall be in effect only from July 1, ~~2012~~ 2013 through June 30, ~~2013~~ 2014.

SECTION *13*. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. 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.

The provisions of this section shall be in effect only from July 1, ~~2012~~ 2013 through June 30, ~~2013~~ 2014.

SECTION *14*. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. MEDICAL SERVICES - GENERAL MEDICAID RATE METHODOLOGY PROVISIONS.

(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 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 ~~review~~ *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.

The provisions of this section shall be in effect only from July 1, ~~2012~~ 2013 through June 30, ~~2013~~ 2014.

SECTION *15*. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. 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.

SECTION *16*. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. 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 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.

SECTION *17*. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. MEDICAL SERVICES - STATE MEDICAID PROGRAM/PERSONAL CARE PROGRAM.

(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 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.

The provisions of this section shall be in effect only from July 1, ~~2012~~ 2013 through June 30, ~~2013~~ 2014.

SECTION *18*. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. 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 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, 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 Council as soon as practicable.

(f) This section expires on June 30, ~~2013~~ 2014.

SECTION 19. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. FUND TRANSFER PROVISION - MEDICAID PROGRAM. Notwithstanding the provisions of Initiated Act 1 of 2000, or Arkansas Code 19-12-107 regarding the establishment of the Arkansas Healthy Century Trust Fund, or any other law to the contrary, immediately upon the effective date of this act, the Chief Fiscal Officer of the State shall transfer on his or her books and those of the State Treasurer and Auditor of State the balance of all moneys in excess of one hundred million dollars ($100,000,000) in the Arkansas Healthy Century Trust Fund from the Arkansas Healthy Century Trust Fund to the Medicaid Expansion Program Account of the Tobacco Settlement Program Fund.

SECTION 20. SPECIAL LANGUAGE. NOT TO BE INCORPORATED INTO THE ARKANSAS CODE NOR PUBLISHED SEPARATELY AS SPECIAL, LOCAL AND TEMPORARY LAW. FUND TRANSFER PROVISION - MEDICAID PROGRAM. Notwithstanding the provisions of Initiated Act 1 of 2000, or Arkansas Code 19-12-104 regarding the establishment and administration of the Tobacco Settlement Cash Holding Fund, or any other laws to the contrary, the entire amount of the settlement funds received, approximately twenty-two million seven hundred sixty-eight thousand one hundred twenty-six dollars ($22,768,126), or so much as is actually awarded and received by the state, through the settlement agreement in the nearly decade old dispute between Arkansas and the tobacco companies that signed the Master Settlement Agreement, shall be deposited into the Tobacco Settlement Cash Holding Fund and not distributed under the provisions of the Tobacco Settlement Proceeds Act, but instead such settlement funds shall be deposited directly into and credited to the Medicaid Expansion Program Account of the Tobacco Settlement Program Fund.

SECTION 21. SPECIAL LANGUAGE. HEALTH CARE INDEPENDENCE ACT OF 2013. Arkansas Code Title 20, Chapter 77, is amended to create a new subchapter to read as follows:

Subchapter 21 – Health Care Independence Act of 2013

20-77-2101. Title.

This act shall be known and may be cited as the "Health Care Independence Act of 2013".

20-77-2102. Legislative intent.

(a) Notwithstanding any general or specific laws to the contrary, the Department of Human Services is to explore design options that reform the Medicaid Program utilizing the Health Care Independence Act of 2013 so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program utilizing competitive and value-based purchasing to:

(1) Maximize the available service options;

(2) Promote accountability, personal responsibility, and transparency;

(3) Encourage and reward healthy outcomes and responsible

choices; and

(4) Promote efficiencies that will deliver value to the taxpayers.

(b)(1) It is the intent of the General Assembly that the State of Arkansas through the Department of Human Services shall utilize a private insurance option for “low-risk” adults.

(2) The Health Care Independence Act of 2013 shall ensure that:

(A) Private health care options increase and government-operated programs such as Medicaid decrease; and

(B) Decisions about the design, operation and implementation of this option, including cost, remain within the purview of the State of Arkansas and not with Washington, D.C.

20-77-2103. Purpose.

(a) The purpose of this subchapter is to:

(1) Improve access to quality health care;

(2) Attract insurance carriers and enhance competition in the Arkansas insurance marketplace;

(3) Promote individually-owned health insurance;

(4) Strengthen personal responsibility through cost-sharing;

(5) Improve continuity of coverage;

(6) Reduce the size of the state-administered Medicaid program;

(7) Encourage appropriate care, including early intervention, prevention, and wellness;

(8) Increase quality and delivery system efficiencies;

(9) Facilitate Arkansas’s continued payment innovation, delivery system reform, and market-driven improvements;

(10) Discourage over-utilization; and

(11) Reduce waste, fraud, and abuse.

(b) The State of Arkansas shall take an integrated and market-based approach to covering low-income Arkansans through offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program.

20-77-2104. Definitions.

As used in this subchapter:

(1) "Carrier" means a private entity certified by the State Insurance Department and offering plans through the Health Insurance Marketplace;

(2) "Cost sharing" means the portion of the cost of a covered medical service that must be paid by or on behalf of eligible individuals, consisting of copayments or coinsurance but not deductibles;

(3) "Eligible individuals" means individuals who:

(A) Are adults between nineteen (19) years of age and sixty-five (65) years of age with an income that is equal to or less than one hundred thirty-eight percent (138%) of the federal poverty level, including without limitation individuals who would not be eligible for Medicaid under laws and rules in effect on January 1, 2013;

(B) Have been authenticated to be a United States citizen or documented qualified alien according to the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, as existing on January 1, 2013; and

(C) Are not determined to be more effectively covered through the standard Medicaid program, such as an individual who is medically frail or other individuals with exceptional medical needs for whom coverage through the Health Insurance Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care;

(4) "Healthcare coverage" means healthcare benefits as defined by certification or rules, or both, promulgated by the State Insurance Department for the Qualified Health Plans or available on the marketplace;

(5) "Health Insurance Marketplace" means the vehicle created to help individuals, families, and small businesses in Arkansas shop for and select health insurance coverage in a way that permits comparison of available Qualified Health Plan based upon price, benefits, services, and quality, regardless of the governance structure of the marketplace;

(6) "Premium" means a charge that must be paid as a condition of enrolling in health care coverage;

(7) "Program" means the Health Care Independence Program established by this subchapter; and

(8) "Qualified Health Plan" means a State Insurance Department certified individual health insurance plan offered by a carrier through the Health Insurance Marketplace.

20-77-2105. Administration of the Health Care Independence Program.

(a) The Department of Human Services shall:

(1) Create and administer the Health Care Independence Program; and

(2) Submit Medicaid State Plan Amendments and apply for any federal waivers necessary to implement the program in a manner consistent with this subchapter.

(b)(1) Implementation of the program is conditioned upon the receipt of necessary federal approvals.

(2) If the Department of Human Services does not receive the necessary federal approvals, the program shall not be implemented.

(c) The program shall include premium assistance for eligible individuals to enable their enrollment in a Qualified Health Plan through the Health Insurance Marketplace.

(d)(1) The Department of Human Services is specifically authorized to pay premiums and supplemental cost-sharing subsidies directly to the Qualified Health Plans for enrolled eligible individuals.

(2) The intent of the payments under subdivision (d)(1) of this section is to increase participation and competition in the health insurance market, intensify price pressures, and reduce costs for both publicly and privately funded health care.

(e) To the extent allowable by law:

(1) The Department of Human Services shall pursue strategies that promote insurance coverage of children in their parents' or caregivers' plan, including children eligible for the ARKids First Program Act, § 20-77-1101 et seq., commonly known as the "ARKids B program"; and

(2) Upon the receipt of necessary federal approval, during calendar year 2015 the Department of Human Services shall include and transition to the Health Insurance Marketplace:

(A) Children eligible for the ARKids First Program Act, § 20-77-1101 et seq.; and

(B) Populations under Medicaid from zero percent (0%) of the federal poverty level to seventeen percent (17%) of the federal poverty level.

(3) The Department of Human Services shall develop and implement

a strategy to inform Medicaid recipient populations whose needs would be reduced or better served through participation in the Health Insurance Marketplace.

(f) The program shall include allowable cost sharing for eligible individuals that is comparable to that for individuals in the same income range in the private insurance market and is structured to enhance eligible individuals' investment in their health care purchasing decisions.

(g)(1) The State Insurance Department and Department of Human Services shall administer and promulgate rules to administer the program authorized under this subchapter.

(2) No less than thirty (30) days before the State Insurance Department and Department of Human Services begin promulgating a rule under this subchapter, the proposed rule shall be presented to the Legislative Council.

(h) The program authorized under this subchapter shall terminate within one hundred twenty (120) days after a reduction in any of the following federal medical assistance percentages:

(1) One hundred percent (100%) in 2014, 2015, or 2016;

(2) Ninety-five percent (95%) in 2017;

(3) Ninety-four percent (94%) in 2018;

(4) Ninety-three percent (93%) in 2019; and

(5) Ninety percent (90%) in 2020 or any year after 2020.

(i) An eligible individual enrolled in the program shall affirmatively acknowledge that:

(1) The program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The program is subject to cancellation upon appropriate notice; and

(3) The program is not an entitlement program.

(j)(1) The Department of Human Services shall develop a model and seek approval from the Center for Medicare and Medicaid Services to allow a limited number of enrollees to participate in a pilot program testing the viability of a Health Savings Account or a Medical Savings Account.

(2) The pilot program shall be implemented during calendar year 2015.

(3) As soon as practicable, the Department of Human Services shall seek conditional federal approval to place Health Saving Accounts and Medical Savings Accounts on the Health Insurance Marketplace.

(k)(1) State obligations for uncompensated care shall be projected, tracked, and reported to identify potential incremental future decreases.

(2) The Department of Human Services shall recommend appropriate adjustments to the General Assembly.

(3) Adjustments shall be made by the General Assembly as appropriate.

(l) The Department of Human Services shall track the Hospital Assessment Fee as defined in § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.

(m) On a quarterly basis, the Department of Human Services and the State Insurance Department shall report to the Legislative Council or to the Joint Budget Committee if the General Assembly is in session, available information regarding:

(1) Program enrollment;

(2) Patient experience;

(3) Economic impact including enrollment distribution;

(4) Carrier competition; and

(5) Avoided uncompensated care.

20-77-2106. Standards of healthcare coverage through the Health Insurance Marketplace.

(a) Healthcare coverage shall be achieved through a qualified health plan at the silver level as provided in 42 U.S.C. §§ 18022 and 18071, as existing on January 1, 2013, that restricts cost sharing to amounts that do not exceed Medicaid cost-sharing limitations.

(b) All participating carriers in the Health Insurance Marketplace shall offer healthcare coverage conforming to the requirements of this subchapter.

(c) To assure price competitive choice among healthcare coverage options, the State Insurance Department shall assure that at least two (2) qualified health plans are offered in each county in the state.

(d) Health insurance carriers offering health care coverage for program eligible individuals shall participate in Arkansas Payment

Improvement Initiatives including:

(1) Assignment of primary care clinician;

(2) Support for patient-centered medical home; and

(3) Access of clinical performance data for providers.

(e) On or before July 1, 2013, the State Insurance Department shall implement through certification requirements, rule, or both the applicable provisions of this subchapter.

20-77-2107. Enrollment.

(a) The General Assembly shall assure that a mechanism within the Health Insurance Marketplace is established and operated to facilitate enrollment of eligible individuals.

(b) The enrollment mechanism shall include an automatic verification system to guard against waste, fraud, and abuse in the program.

20-77-2108. Effective date.

This subchapter shall be in effect until June 30, 2017, unless amended or extended by the General Assembly.

SECTION 22. SPECIAL LANGUAGE. Arkansas Code Title 19, Chapter 5, Subchapter 11, is amended to add an additional section to read as follows:

19-5-1140. Health Care Independence Program Trust Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "Health Care Independence Program Trust Fund".

(b)(1) The Health Care Independence Program Trust Fund may consist of moneys saved and accrued under the Health Care Independence Act of 2013, § 20-77-2101 et seq., including without limitation:

(A) Increases in premium tax collections;

(B) Reductions in uncompensated care; and

(C) Other spending reductions resulting from the Health Care Independence Act of 2013, § 20-77-2101 et seq.

(2) The fund shall also consist of other revenues and funds authorized by law.

(c) The fund may be used by the Department of Human Services to pay for future obligations under the Health Care Independence Program created by

the Health Care Independence Act of 2013, § 20-77-2101 et seq.

SECTION 23. SPECIAL LANGUAGE. DO NOT CODIFY. (a) The implementation of Sections 18 and 19 of this act is suspended until an appropriation for implementation is passed by a three-fourths vote of both houses of the Eighty-Ninth General Assembly.

(b) If an appropriation for implementation is not passed by the Eighty-Ninth General Assembly, Sections 18 and 19 of this act are void.

SECTION *24*. 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 Procurement Law, the General Accounting and Budgetary Procedures Law, the Revenue Stabilization 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.

SECTION *25*. LEGISLATIVE INTENT. It is the intent of the General Assembly that any funds disbursed under the authority of the appropriations contained in this act shall be in compliance with the stated reasons for which this act was adopted, as evidenced by the Agency Requests, Executive Recommendations and Legislative Recommendations contained in the budget manuals prepared by the Department of Finance and Administration, letters, or summarized oral testimony in the official minutes of the Arkansas Legislative Council or Joint Budget Committee which relate to its passage and adoption.

SECTION 26. EMERGENCY CLAUSE. (a) It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a one (1) year period; that the effectiveness of this Act on July 1, 2013, is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the legislative session, the delay in the effective date of this Act beyond July 1, 2013, could work irreparable harm upon the proper administration and provision of essential governmental

programs. Therefore, an emergency is hereby declared to exist and Sections 1-20 and 24-25 of this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 2013.

(b) It is found and determined by the General Assembly of the State of Arkansas that the Health Care Independence Program requires private insurance companies to create, present to the Department of Human Services for approval, implement, and market a new kind of insurance policy; and that the private insurance companies need certainty about the law creating the Health Care Independence Program before fully investing time, funds, personnel, and other resources to the development of the new insurance policies. Therefore, an emergency is declared to exist, and Sections 21-23 of this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/Joint Budget Committee