

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

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As Engrossed: H4/1/19
A Bill

HOUSE BILL 1821

By: Representatives Murdock, F. Allen, Beck, Blake, Breaux, Burch, Christiansen, Clowney, Coleman, C. Cooper, Crawford, Deffenbaugh, Della Rosa, D. Douglas, Evans, K. Ferguson, C. Fite, V. Flowers, D. Garner, Glover, Godfrey, Hawks, M. Hodges, Holcomb, Jett, L. Johnson, Love, Lynch, Magie, J. Mayberry, McCullough, Miller, Nicks, Perry, Richardson, Richey, Rushing, Rye, Scott, S. Smith, Walker, Warren, Watson, D. Whitaker, Wooten
By: Senators K. Hammer, Bond, Caldwell, E. Cheatham, A. Clark, B. Davis, Elliott, G. Leding, B. Sample

For An Act To Be Entitled

AN ACT TO PROVIDE FOR MEDICAID REIMBURSEMENT RATES THAT ADDRESS THE MINIMUM WAGE INCREASES; TO PROVIDE FOR IMMEDIATE AND ONGOING REGULAR REVIEWS OF MEDICAID REIMBURSEMENT RATES AND METHODOLOGIES; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO PROVIDE FOR MEDICAID REIMBURSEMENT RATES THAT ADDRESS THE MINIMUM WAGE INCREASES; TO PROVIDE FOR IMMEDIATE AND ONGOING REGULAR REVIEWS OF MEDICAID REIMBURSEMENT RATES AND METHODOLOGIES; AND TO DECLARE AN EMERGENCY.

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

SECTION 1. Arkansas Code Title 20, Chapter 77, is amended to add an additional subchapter to read as follows:

Subchapter 29 – Medicaid Reimbursement Review Act of 2019

20-77-2901. Title.



This subchapter shall be known and may be cited as the "Medicaid Reimbursement Review Act of 2019."

20-77-2902. Legislative findings.

The General Assembly finds that:

(1) The Arkansas Health Reform Legislative Task Force and Acts 2017, No. 802 required the Department of Human Services to achieve eight hundred thirty-five million dollars (\$835,000,000) in savings in the Arkansas Medicaid Program over the five-year period of fiscal years 2017 through 2021;

(2) According to the fiscal year 2019 second quarter scorecard, the department reported that eight hundred eighty-eight million dollars (\$888,000,000) has already been saved, which is six percent (6%) more than the total savings target less than halfway through the five-year measurement period;

(3) The target savings amount set by the Arkansas Health Reform Legislative Task Force through the second quarter of fiscal year 2019 is three hundred sixteen million dollars (\$316,000,000), meaning Medicaid has spent five hundred seventy-two million dollars (\$572,000,000) less than the legislature and the Department of Human Services expected through the second quarter of fiscal year 2019, making funding available for other Medicaid spending;

(4) Arkansas voters approved an Initiated Act in the November 2018 election that increased the minimum wage from eight dollars and fifty cents (\$8.50) per hour to nine dollars and twenty-five cents (\$9.25) per hour on January 1, 2019, an increase of eight and eight-tenths percent (8.8%);

(5) The approved Initiated Act included two (2) additional minimum wage increases to ten dollars (\$10.00) per hour on January 1, 2020, and eleven dollars (\$11.00) on January 1, 2021;

(6) The minimum wage increases approved in 2018 are in addition staged increases from six dollars and twenty-five cents (\$6.25) per hour to eight dollars and fifty cents (\$8.50) per hour that were approved by the voters in the November 2014 election;

(7) Minimum wage increases affect home and community Medicaid providers, many of whom pay employees the minimum wage or an amount just higher than the minimum wage;

(8) Medicaid providers must maintain sufficient wage levels in

order to compete with other employers with even higher starting salaries for unskilled, entry-level jobs;

(9) The department has not increased rates paid to providers to reflect the past and future increases in the minimum wage;

(10) Medicaid providers are required to increase wages provided for by law, and the Medicaid providers want to recognize the difficult and important work their employees do every day caring for some of the state's most vulnerable residents;

(11) Medicaid providers cannot continue to meet the increases in the minimum wage and increases in other operating costs, while the Medicaid reimbursement rate remains stagnant; and

(12) There is no procedure in place for Medicaid reimbursement rates to be reviewed and updated on a regular basis to reflect changes in the cost of providing services.

20-77-2903. Minimum wage-based rate increases.

(a) The Department of Human Services shall submit all necessary Medicaid state plan amendments, waiver amendments, and Medicaid manual revisions necessary to implement an eight and eight-tenths percent (8.8%) increase to the rates paid for the following services or services provided under a successor program:

(1) Early intervention day treatment services;

(2) Adult development day treatment services;

(3) Personal care services paid by the unit and those paid by a multihour daily rate;

(4) Attendant care and respite care services under the ARChoices waiver or its successor; and

(5) Substance abuse treatment services.

(b)(1) The department shall use best efforts to make the rate increases in subsection (a) of this section effective for services on and after July 1, 2019.

(2) The rate increases shall not be implemented until approved by the Centers for Medicare and Medicaid Services if federal approval is required.

(c) Effective immediately, person-centered service plans developed under the Community and Employment Supports waiver shall reflect the

additional staff costs resulting from the increases in the minimum wage of Arkansas.

(d) The department shall:

(1) Provide copies of all state plan amendments, waiver amendments, manual revisions, documentation, and correspondence submitted to or received from the Centers for Medicare and Medicaid Services in regard to this section to:

(A) The Administrative Rules Subcommittee of the Legislative Council;

(B) The affected Medicaid providers; and

(C) The public; and

(2) Work jointly with provider representatives in obtaining and maintaining approval for any amendments required to effectuate the increases in this section.

20-77-2904. Designation of schedule of review of rates and reimbursement methodologies.

(a) The Department of Human Services shall establish a schedule, by rule, that will result in the review of the Medicaid rates and reimbursement methodology for each healthcare provider type at least once every three (3) years.

(b) In establishing the schedule of provider types for review, the department shall, to the greatest extent possible, provide for the review of provider types constituting approximately one-third (1/3) of the fee-for-service Medicaid budget each year.

20-77-2905. Review of rates and reimbursement methodologies.

(a) The Department of Human Services shall review Medicaid rates and reimbursement methodologies on the schedule provided for in § 20-77-2904.

(b) The department shall utilize the services of an independent consulting firm with experience in evaluating and designing healthcare reimbursement methodologies to assist in the review of rates and reimbursement methodologies.

(c) The department shall consider the following factors in the review:

(1) The extent to which existing rates or reimbursement methodologies allow providers to operate on a solvent basis;

(2) The average percent of provider costs covered by existing rates or reimbursement methodologies;

(3) The allocation of provider costs among direct services, administrative costs, and overhead;

(4) The extent and amount of uncompensated care delivered by providers;

(5) The level of and changes in wages paid by providers to employees and their ability to attract and retain a high quality workforce;

(6) The capital infrastructure needs of Medicaid providers;

(7) Any incentives or disincentives for the provision of high quality care incorporated in the existing rates or reimbursement methodologies;

(8) Any incentives for quality care that could be incorporated into rates or reimbursement methodologies;

(9) A comparison of current Medicaid rates to the rates paid by Medicare and other payors;

(10) The availability of other non-Medicaid state or federal funding for the services provided;

(11) The impact of state and federal regulatory mandates on the cost of providing services and the extent to which provider costs could be reduced by elimination of any of those mandates;

(12) The factors of economy, efficiency, quality of care, and equal access required by the Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396a(a)(30)(A), as existing on January 1, 2019, and in federal regulations at 42 C.F.R. Part 447, as existing on January 1, 2019,; and

(13) Any other factors that are relevant in reviewing the Medicaid rates and reimbursement methodologies.

(d) The department shall provide opportunity for meaningful input from interested parties regarding the Medicaid reimbursement methodologies under review each year, including receiving written comments and holding at least one (1) public hearing for comment before the recommendations of the department are finalized.

(e)(1) In order to ensure that provider input and expertise is utilized, the department shall consult with representatives of any provider group whose reimbursement is being reviewed from the initiation of the review through completion of the final recommendations.

(2) Provider input and expertise shall include without limitation:

(A) Review of underlying data used by the department in the review of rates and reimbursement methodologies;

(B) The opportunity to propose alternative reimbursement methodologies for the consideration of the department; and

(C) The opportunity to provide comment on the recommendations of the department before the recommendations or rates are finalized.

20-77-2906. Report.

(a) No later than October 31 of each year, the Department of Human Services shall issue a report containing its recommendations for changes to the Medicaid rates or reimbursement methodologies reviewed during that year.

(b) In addition to recommendations for changes in rates and reimbursement methodologies, the report shall include:

(1) For each provider type reviewed, the manner and extent to which each of the factors in § 20-77-2905(c) was considered in the review and recommendations;

(2) A summary of comments received at any public hearings or in writing and the response of the department to those comments; and

(3) Comments provided by provider representatives under § 20-77-2905(e)(2)(C) and the response of the department to the comments.

20-77-2907. Legislative review.

(a) The report of the Department of Human Services shall be submitted to the Legislative Council, which shall assign the report to the Administrative Rules Subcommittee of the Legislative Council for review.

(b)(1) Each recommendation for changes to any rates or reimbursement methodologies included in the report shall be considered approved unless a majority of a quorum present request that the Administrative Rules Subcommittee vote on the question of approving the specific recommendation.

(2) If the Administrative Rules Subcommittee votes on a specific recommendation in the report, the recommendation shall be approved unless a majority of a quorum present vote for the recommendation to not be approved.

(c)(1) Each recommendation in the report that is approved by the

Administrative Rules Subcommittee under subdivision (b)(1) or (2) of this section shall be considered approved by the Legislative Council unless a majority of a quorum present request that the Legislative Council vote on the issue of approving the specific recommendation.

(2) If the Legislative Council votes on the issue of approving a specific recommendation in the report, the recommendation shall be approved unless a majority of a quorum present vote for the specific recommendation to not be approved.

20-77-2908. Implementation.

For every change to a Medicaid rate or reimbursement methodology included in the report that is not disapproved by the Legislative Council, the Department of Human Services shall submit any necessary state plan amendment, waiver, or waiver amendment to the Centers for Medicare and Medicaid Services to implement such change on or before July 1 of the following year.

20-77-2909. Medicaid provider-led organized care.

(a)(1) The Department of Human Services shall direct its contracted actuaries to recalculate the capitated rates as established for 2019 for the risk-based provider organization under the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq., to ensure that the capitated rates account for the reimbursement changes in § 20-77-2903, including adjustments to reflect minimum wage increases as specified under § 20-77-2903(c).

(2) The department shall increase the capitated rates as established for 2019 in accordance with the recalculation required in subdivision (a)(1) of this section.

(b) If the department or an actuary of the department revises the capitated rates for the risk-based provider organization, the department shall consider or direct the actuary to explicitly consider the factors listed in § 20-77-2905(c) and provide a written explanation of the manner and extent that each of the factors was considered in the calculation of the new capitated rates.

(c)(1) The department may not submit any proposed capitation rates of the risk-based provider organization to the Centers for Medicare and Medicaid Services until the department demonstrates that the department or an actuary

of the department has considered the factors in § 20-77-2905(c) in development of the capitated rates.

(2) The requirement under subdivision (c)(1) of this section includes the revised capitated rates resulting from the reimbursement changes in § 20-77-2903.

20-77-2910. Remedies.

A Medicaid provider or beneficiary may bring an action for equitable relief in any court of competent jurisdiction against the Department of Human Services or any successor state agency for failure to perform the actions required by this subchapter.

SECTION 2. Arkansas Code § 10-3-309(f), regarding the reasons why a legislative committee may vote not to approve a rule, is amended to read as follows:

(f)(1) A Except as provided in subdivision (f)(4) of this section, a committee or subcommittee under this section may vote to not approve a rule under this section only if the rule is inconsistent with:

- (A) State or federal law; or
- (B) Legislative intent.

(2) A committee or subcommittee under this section voting not to approve a rule under this section shall state the grounds under subdivision (f)(1) of this section when not approving a rule.

(3) A committee or subcommittee under this section considering a rule submitted in accordance with § 20-7-604(d)(2)(D), concerning exemptions from the Prescription Drug Monitoring Program, is not required to state the grounds required under subdivision (f)(1) of this section when not approving a rule.

(4) A committee or subcommittee under this section considering a recommendation submitted by the Department of Human Services under the Medicaid Reimbursement Review Act of 2019, § 20-77-2901 et seq., is not subject to subdivisions (f)(1) and (2) of this section.

SECTION 3. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that increases in the minimum wage have put Medicaid providers at risk of being unable to continue to provide

healthcare services with current Medicaid reimbursement rates; that a rate increase in response to the increases in the minimum wage should be implemented as soon as possible in order to allow Medicaid providers to continue to provide services to Medicaid beneficiaries; that this act requires the Department of Human Services to implement a rate review methodology and procedure; that this act may require that the Department of Human Services submit a state plan amendment or waiver, or both, to the Centers for Medicare and Medicaid Services; that the state plan amendment or waiver, or both, impacts healthcare providers and certain individuals enrolled in the Arkansas Medicaid Program; and that this act is immediately necessary because the Department of Human Services needs to be able to make the state plan amendment request or waiver request, or both, at the earliest possible date to ensure certainty in the reimbursement rates of the Arkansas Medicaid Program. Therefore, an emergency is declared to exist, and 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/Murdock