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

State of Arkansas
95th General Assembly
Regular Session, 2025

A Bill

SENATE BILL 543

By: Senator B. Davis
By: Representative L. Johnson

For An Act To Be Entitled

AN ACT TO REQUIRE CERTAIN REIMBURSEMENT RATES FOR HOME- AND COMMUNITY-BASED SERVICES WITHIN RISK-BASED PROVIDER ORGANIZATIONS; AND FOR OTHER PURPOSES.

Subtitle

TO REQUIRE CERTAIN REIMBURSEMENT RATES FOR HOME- AND COMMUNITY-BASED SERVICES WITHIN RISK-BASED PROVIDER ORGANIZATIONS.

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

SECTION 1. Arkansas Code § 20-77-2706(d)(1), concerning the characteristics and duties of a risk-based provider organization under the Medicaid Provider-Led Organized Care Act, is amended to read as follows:

(d)(1) Except as provided in subdivision (d)(2) of this section, reimbursement rates paid by a risk-based provider organization to direct service providers shall:

(A) Be determined by mutual agreement of the risk-based provider organization and direct service provider ~~without regard to Medicaid provider rates established by the Department of Human Services~~ if the reimbursement rates are not less than the minimum rates established under § 20-77-2709; and

(B) Assure efficiency, economy, quality, and equal access to enrollable Medicaid beneficiary populations in the same manner as to individuals who are not covered by the Arkansas Medicaid Program.

SECTION 2. Arkansas Code § 20-77-2706(e)(1), concerning the characteristics and duties of a risk-based provider organization under the Medicaid Provider-Led Organized Care Act, is amended to read as follows:

(e)(1) Except as provided in subdivision (e)(2) of this section, all policies and procedures regarding the provision of healthcare services by a direct service provider shall:

(A) Be determined by mutual agreement of the risk-based provider organization and the direct service provider ~~without regard to Medicaid provider rates established by the Department of Human Services~~ if the reimbursement rates are not less than the minimum rates established under § 20-77-2709; and

(B) Assure efficiency, economy, quality, and equal access to the enrollable Medicaid beneficiary population in the same manner as individuals who are not covered by the Arkansas Medicaid Program.

SECTION 3. Arkansas Code Title 20, Chapter 77, Subchapter 27, is amended to add an additional section to read as follows:

20-77-2709. Home- and community-based services — Rate setting.

(a)(1) An allowance within the capitation rates for a risk-based provider organization shall not be less than the amount needed to pay providers the rates arrived at through a rate study to be completed by October 1, 2025.

(2) The rates from a rate study as described in subdivision (a)(1) of this section serve as the minimums that risk-based provider organizations may pay for home- and community-based services, as authorized in 42 C.F.R. § 438.6, as existing on January 1, 2025.

(b) The rate study under subdivision (a)(1) of this section shall:

(1) Cover services in the Community and Employment Support 1915(c) waiver and the Community Support System Provider program; and

(2) Accurately capture provider costs and other relevant considerations that promote economy, efficiency, quality of care, and equal access as required by the Centers for Medicare & Medicaid Services under 42 U.S.C. § 1396a, as existing on January 1, 2025, and in federal regulations under 42 C.F.R. Part 447, as existing on January 1, 2025.

(c)(1) The Department of Human Services shall develop the cost factors and other criteria for the rate study with input from home- and community-

based service providers.

(2) As no rate study for home- and community-based service providers has been conducted since the risk-based provider organizations began serving the state, if the outcome of the rate study under subdivision (a)(1) of this section produces an increase greater than ten percent (10%), the department may be phase in a rate increase across two (2) years as authorized by state appropriations and budgets.

(3) The department shall conduct a full provider rate review in accordance with the published rate review schedule to ensure that rates remain adequate and aligned with actual costs.