

Hall of the House of Representatives

89th General Assembly - Regular Session, 2013
Amendment Form

Subtitle of House Bill No. 1219

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

Amendment No. 4 to House Bill No. 1219

Amend House Bill No. 1219 as engrossed, H4/6/13 (version: 04/06/2013 01:22:53 PM):

Page 2, line 5, delete "9" and substitute "8"

AND

Page 2, line 7, delete "9" and substitute "8"

AND

Page 2, line 8, delete "5" and substitute "4"

AND

Page 2, line 16, delete "15" and substitute "13"

AND

Page 2, line 17, delete "14" and substitute "11"

AND

Page 2, delete line 22 in its entirety

AND

Page 2, line 25, delete "71" and substitute "68"

AND

Page 2, line 29, delete "15" and substitute "14"

AND



Page 2, line 34, delete "14" and substitute "10"

AND

Page 2, line 36, delete "4" and substitute "2"

AND

Page 3, line 2, delete "11" and substitute "10"

AND

Page 3, delete line 8 in its entirety

AND

Page 3, delete line 14 in its entirety

AND

Page 3, delete line 16 in its entirety

AND

Page 3, line 19, delete "19" and substitute "18"

AND

Page 3, line 23, delete "14" and substitute "12"

AND

Page 3, line 25, delete "352" and substitute "322"

AND

Appropriately renumber all ITEM NUMBERS in SECTION 1

AND

Insert an additional section immediately following SECTION 1 of the bill to read as follows:

"

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
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(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	<u>2</u>	GRADE C109
	MAX. NO. OF EMPLOYEES	35	"

AND

Insert an additional section immediately following SECTION 2 of the bill to read as follows:

"

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."

AND

Page 4, line 9, delete "\$17,523,771" and substitute "\$16,178,191"

AND

Page 4, line 11, delete "5,817,834" and substitute "5,441,071"

AND

Page 4, line 14, delete "3,618,107" and substitute "3,541,565"

AND

Page 4, line 15, delete "246,340" and substitute "233,728"

AND

Page 4, line 17, delete "150,000" and substitute "144,388"

AND

Page 4, line 20, delete "\$28,417,676" and substitute "\$26,600,567"

AND

Insert an additional section immediately following SECTION 3 of the bill to read as follows:

"

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	<u>\$1,968,343</u>

AND

Immediately following SECTION 17 of the bill, add additional sections to the bill to read as follows:

"

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.

(1) 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."

AND

Page 15, delete lines 15 through 25 in their entirety and substitute the following:

"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."

AND

Appropriately renumber the SECTION numbers of the bill.

The Amendment was read _____
By: Representative Baird
JKG/JKG - 04-10-2013 13:23:41
JKG148

Chief Clerk