ARKANSAS SENATE

88th General Assembly - Regular Session, 2011

Amendment Form

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Subtitle of Senate Bill No. 341

TO ESTABLISH A MEDICAID PROVIDER FEE FOR SERVICES PROVIDED UNDER THE ALTERNATIVE COMMUNITY SERVICES WAIVER ADMINISTERED BY DDS.

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Amendment No. 1 to Senate Bill No. 341

Amend Senate Bill No. 341 as originally introduced:

Add Senators S. Harrelson, P. Malone, D. Wyatt as cosponsors of the bill

AND

Delete the title in its entirety and substitute the following:
"AN ACT TO ESTABLISH A MEDICAID PROVIDER FEE FOR SERVICES PROVIDED UNDER THE ALTERNATIVE COMMUNITY SERVICES WAIVER ADMINISTERED BY THE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES OF THE DEPARTMENT OF HUMAN SERVICES; AND FOR OTHER PURPOSES."

AND

Delete the subtitle in its entirety and substitute the following:
"TO ESTABLISH A MEDICAID PROVIDER FEE FOR SERVICES PROVIDED UNDER THE ALTERNATIVE COMMUNITY SERVICES WAIVER ADMINISTERED BY DDS."

AND

Strike everything after the enacting clause and substitute the following:

Subchapter 10 --Alternative Community Services Waiver Provider Fee

"SECTION 1. Arkansas Code Title 20, Chapter 48 is amended to add an additional subchapter to read as follows:

20-48-1001. Definitions.

As used in this subchapter:

(1) "Alternative Community Services Waiver" means the home and community-based waiver program authorized by the Centers for Medicare and Medicaid Services under § 1915(c) of the Social Security Act, 42 U.S.C. § 1396 et seq., and administered by the Division of Developmental Disabilities Services of the Department of Human Services;

(2)(A) "Gross receipts" means compensation paid to a provider for services provided through, or identical to those provided under the Alternative Community Services Waiver.

(B) "Gross receipts" does not include charitable contributions; and

(3) "Medicaid" means the medical assistance program established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and administered by the Division of Medical Services of the Department of Human Services.

20-48-1002. Provider fee.

(a)(1) There is levied a provider fee on services provided through, or identical to those provided under, the Alternative Community Services Waiver to be calculated in accordance with this section.

(2) The provider fee shall be an amount calculated by the Division of Medical Services of the Department of Human Services to produce a provider fee payment equal to six percent (6%) of the gross receipts received by each provider for services provided through, or identical to those provided under, the Alternative Community Services Waiver.

(b)(1)(A) The provider fee shall be payable in monthly payments.

(B) Each monthly payment shall be due and payable for the previous month by the thirtieth day of each month.

(2) The division shall seek approval from the Centers for Medicare and Medicaid Services to treat the provider fee of a provider of services through, or identical to those provided under, the Alternative Community Services Waiver as an allowable cost for Medicaid reimbursement purposes.

(c) A provider of services provided through, or identical to those provided under, the Alternative Community Services Waiver shall not be guaranteed, expressly or otherwise, that any additional moneys paid to the provider for services under the Alternative Community Services Waiver will equal or exceed the amount of its provider fee.

(d)(1) The division shall ensure that the rate of assessment of the provider fee established in this section equals, but does not exceed, the maximum rate of assessment established under federal law and rule for health care-related provider fees without reduction in federal financial participation in Medicaid.

(2) If the division determines that the rate of assessment of the provider fee established in this section exceeds the maximum rate of assessment that federal law and rule allow without reduction in federal financial participation in Medicaid, the division shall lower the rate of assessment of the provider fee to a rate that is equal to the maximum rate that federal law and rule allow without reduction in federal financial participation in Medicaid.

20-48-1003. Administration.

(a) The administration of this subchapter shall be exercised by the Director of the Division of Medical Services of the Department of Human Services and shall be subject to the provisions of the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(b)(1) In accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the Division of Medical Services of the Department of Human Services shall promulgate rules and prescribe forms for:

(A) The proper imposition and collection of the provider fee;

(B)(i) The enforcement of this subchapter, including without limitation certification nonrenewal, letters of caution, sanctions, or fines.

(ii)(a) The fine for failure to comply with payment and reporting requirements shall be at least one thousand dollars ($1,000) but no more than one thousand five hundred dollars ($1,500).

(b) The fine and, if applicable, the outstanding balance of the provider fee shall accrue interest at the maximum rate permitted by law from the date the fine and, if applicable, the provider fee is due until payment of the outstanding balance of the fine and, if applicable, the provider fee;

(C) The format for reporting gross receipts; and

(D) The administration of this subchapter.

(2) The rules shall not grant any exceptions to, or exceptions from, the provider fee.

20-48-1004. Use of funds.

(a)(1) The provider fee assessed and collected under this subchapter shall be deposited into a designated account within the Arkansas Medicaid Program Trust Fund.

(2) The designated account shall be separate and distinct from the general fund and shall be supplementary to the trust fund.

(3)(A) Funds in the designated account shall be placed in an interest bearing account.

(B) Earnings on funds in the designated account shall remain a part of the designated account and shall not be deposited into the general fund.

(4) The designated account moneys in the trust fund and the matching federal financial participation under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., shall be used only as follows:

(A) A minimum of ninety percent (90%) of the revenues of the provider fee assessed and collected under this subchapter shall be used for the support and enhancement of services under the Alternative Community Services Waiver to persons with developmental disabilities; and

(B) An amount not to exceed ten percent (10%) of the revenues of the provider fee assessed and collected under this subchapter may be used by the Division of Medical Services of the Department of Human Services.

(b)(1) The designated account moneys in the trust fund from the provider fee assessed and collected under this subchapter that are unused at the end of a fiscal year shall be carried forward.

(2) The designated account moneys in the trust fund from the provider fee assessed and collected under this subchapter may not be used to supplant other local, state, or federal funds.

(3) The designated account moneys in the trust fund from the provider fee assessed and collected under this subchapter shall be exempt

from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues.

20-48-1005. Effectiveness and cessation.

The assessment imposed under § 20-48-1002 shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax or not eligible for federal financial participation under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq."

The Amendment was read the first time, rules suspended and read the second time and _____

By: Senator Laverty

MGF/CDS - 02/22/11 04:56 _____

MGF251 **Secretary**