State of Arkansas
93rd General Assembly
Regular Session, 2021

A Bill

SENATE BILL 295

By: Senator Flippo
By: Representative Lundstrum

For An Act To Be Entitled

AN ACT TO PROMOTE INTEGRITY IN WELFARE PROGRAMS; TO AMEND THE MEDICAID ELIGIBILITY VERIFICATION SYSTEM; AND FOR OTHER PURPOSES.

Subtitle

TO PROMOTE INTEGRITY IN WELFARE PROGRAMS; AND TO AMEND THE MEDICAID ELIGIBILITY VERIFICATION SYSTEM.

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

SECTION 1. DO NOT CODIFY. Legislative findings.

The General Assembly finds that:

(1) The State of Arkansas has lost millions of dollars to waste and fraud in its welfare programs;

(2) Inadequate eligibility verification policies have failed to maintain program integrity; and

(3) As demand for public assistance remains high due to economic uncertainties and closures related to the coronavirus 2019 (COVID-19) pandemic, protecting limited resources for the needy is critical.

SECTION 2. Arkansas Code Title 20, Chapter 76, Subchapter 2, is amended to add an additional section to read as follows:

20-76-215. Program integrity in Supplemental Nutrition Assistance Program.

(a) The Department of Human Services shall adopt the following

procedures to verify eligibility for participation in the Supplemental Nutrition Assistance Program or for receipt of Supplemental Nutrition Assistance Program benefits:

(1) All conditions of eligibility for assistance shall be verified before authorization of assistance and during a redetermination of a recipient's eligibility; and

(2)(A) Except when prohibited by federal law, it is a condition of eligibility for assistance that an applicant or recipient consents to the disclosure of information about the age, residence, citizenship, employment, application for employment, income, and resources of the applicant or recipient that are in the possession of a third party.

(B) The consent of the applicant or recipient is effective to empower any third party to release information requested by the Department of Human Services.

(b)(1) The Department of Human Services shall enter into a data matching agreement with the Office of the Arkansas Lottery, Arkansas Racing Commission, and all other commissions and agencies with relevant information to identify individuals with lottery or gambling winnings.

(2)(A) On at least a monthly basis, the Department of Human Services shall review the information described in subdivision (b)(1) of this section and deny or revoke assistance for the entire household upon verification of any substantial winnings.

(B) A household that has failed to disclose substantial winnings and is identified through the database match has presumptively committed an intentional program violation.

(c) The Department of Human Services shall review information:

(1) From the Department of Health concerning individuals enrolled in assistance that indicates a change in circumstances, including without limitation death certificates, that may affect eligibility, on at least a monthly basis;

(2) From the Division of Workforce Services and the Department of Finance and Administration concerning individuals enrolled in assistance that indicates a change in circumstances that may affect eligibility, including without limitation a change in employment or wages, on at least a quarterly basis;

(3) Concerning individuals enrolled in assistance that indicates

a change in circumstances that may affect eligibility, including without limitation potential changes in residency as identified by out-of-state electronic benefit transfer transactions, on at least a monthly basis; and

(4) From the Department of Corrections and the Division of Correction concerning individuals enrolled in assistance that indicates a change in circumstances that may affect eligibility.

(d) On at least a quarterly basis, the Department of Human Services shall make available to the public on its website data, including without limitation information regarding noncompliance and fraud investigations in assistance for the following aggregate and nonconfidential and nonpersonally identifying information:

(1) The number of assistance cases investigated for intentional program violations or fraud;

(2) The total number of assistance cases referred to the Office of the Attorney General for prosecution;

(3) Improper payments and expenditures;

(4) Monies recovered;

(5) Aggregate data concerning improper payments and ineligible recipients as a percentage of those investigated and reviewed; and

(6) Aggregate amount of funds expended by electronic benefits transfer card transactions in each state outside of Arkansas.

(e) If the Department of Human Services receives information concerning an individual or household enrolled in assistance that indicates a change in circumstances that may affect eligibility, the Department of Human Services shall review the individual's or household's case.

(f) The Department of Human Services may execute a memorandum of understanding with any other state department, agency, or division for information required to be shared between agencies under this section.

(g) Notwithstanding other provisions of law, a household receiving assistance shall be subject to change reporting and report changes in circumstances, established by 7 C.F.R. § 273.12(a)(1), as it existed on January 1, 2021, within ten (10) days of the date the change becomes known to the household.

SECTION 3. Arkansas Code § 20-77-2102 is amended to read as follows:

20-77-2102. Medicaid Eligibility Verification System — Definitions.

(a) The Department of Human Services shall establish and maintain the Medicaid Eligibility Verification System that is designed to prevent fraud in the establishment and maintenance of Medicaid eligibility.

(b)(1) In establishing the Medicaid Eligibility Verification System, the department ~~shall have the flexibility to determine whether the state~~ shall be an "assessment state" ~~or~~ and not a "determination state" for purposes of Medicaid eligibility determinations by the federally facilitated marketplace.

(2) As used in this subsection:

(A) "Assessment state" means a state with a federally facilitated marketplace that can elect to have the federally facilitated marketplace make assessments of Medicaid eligibility and then transfer the account of an individual to the state Medicaid agency for a final determination; and

(B) "Determination state" means a state that requires the eligibility determination made by the federally facilitated marketplace to be accepted by the state Medicaid agency.

(c) Notwithstanding other provisions of law, the department shall not accept Medicaid eligibility determinations from an exchange or marketplace established under 42 U.S.C. § 18041(c) before verifying eligibility independently and making a Medicaid eligibility determination.

SECTION 4. Arkansas Code Title 20, Chapter 77, Subchapter 21, is amended to add additional sections to read as follows:

20-77-2104. Medicaid eligibility verification.

(a) The Department of Human Services shall adopt the following procedures to verify Medicaid eligibility for participation in the Arkansas Medicaid Program or receipt of benefits in the Arkansas Medicaid Program:

(1) All conditions of eligibility for Medicaid assistance shall be verified before authorization of Medicaid assistance and during a redetermination of a recipient's eligibility; and

(2)(A) Except when prohibited by federal law, a condition of eligibility for assistance is that an applicant or recipient consents to the disclosure of information about the age, residence, citizenship, employment, applications for employment, income, and resources of the applicant or recipient that are in the possession of third parties.

(B) The consent described in subdivision (a)(2)(A) of this section shall be effective to empower any third party to release information requested by the Department of Human Services.

(b)(1) The Department of Human Services shall enter into a data matching agreement with the Office of the Arkansas Lottery, Arkansas Racing Commission, and all other commissions and agencies with relevant information to identify individuals with lottery or gambling winnings.

(2)(A) On at least a monthly basis, the Department of Human Services shall review this information and deny or revoke Medicaid assistance upon verification of any substantial winnings.

(B) An individual who has failed to disclose substantial winnings and is identified through the database match has presumptively committed an intentional program violation.

(c) The Department of Human Services shall review information:

(1) From the Department of Health concerning individuals enrolled in Medicaid assistance that indicates a change in circumstances, including without limitation death certificates, that may affect eligibility, on at least a monthly basis;

(2) From the Division of Workforce Services and the Department of Finance and Administration concerning individuals enrolled in assistance that indicates a change in circumstances that may affect eligibility, including without limitation a change in employment or wages, on at least a quarterly basis;

(3) Concerning individuals enrolled in assistance that indicates a change in circumstances that may affect eligibility, including without limitation potential changes in residency as identified by out-of-state electronic benefit transfer transactions, on at least a monthly basis; and

(4) From the Department of Corrections and the Division of Correction concerning individuals enrolled in Medicaid assistance that indicates a change in circumstances that may affect eligibility.

(d) On at least a quarterly basis, the Department of Human Services shall make available to the public on its website data, including without limitation information regarding noncompliance and fraud investigations in assistance for the following aggregate and nonconfidential and nonpersonally identifying information:

(1) The number of assistance cases investigated for intentional

Arkansas Medicaid Program violations or fraud;

(2) The total number of assistance cases referred to the Office of the Attorney General for prosecution;

(3) Improper payments and expenditures;

(4) Monies recovered; and

(5) Aggregate data concerning improper payments and ineligible recipients as a percentage of those investigated and reviewed.

(e) If the Department of Human Services receives information concerning an individual enrolled in Medicaid assistance that indicates a change in circumstances that may affect eligibility, the Department of Human Services shall review the individual's or household's case.

(f) The Department of Human Services may execute a memorandum of understanding with any other state department, agency, or division for information required to be shared between agencies under this section.

20-77-2105. Additional program integrity measures.

(a) Unless required under federal law, the Department of Human Services shall not:

(1) Designate itself as a qualified health entity for the purpose of making presumptive eligibility determinations or for any purpose not expressly authorized by state law;

(2) Accept self-attestation of income, residency, age, household composition, caretaker or relative status, or receipt of other coverage without verification before enrollment; or

(3) Request authority to waive or decline to:

(A) Periodically check any available income-related data sources to verify eligibility; or

(B) Comply with public notice requirements applicable to proposed changes to the Medicaid state plan under 42 C.F.R. §447.205, 42 C.F.R. §447.57, and 42 C.F.R. §440.386.

(b) When the department receives funding for Medicaid contingent on temporary maintenance of effort restrictions or, for any reason, is limited in the department's ability to unenroll individuals, such as restrictions imposed by Section 6008 of the Families First Coronavirus Response Act, Pub. L. No. 116-127, the department shall:

(1) Within sixty (60) days of the expiration of the

restrictions, complete a full audit in which the department shall:

(A) Complete and act on eligibility redeterminations for all cases that have not had a redetermination within the last twelve (12) months;

(B) Request federal approval from the Centers for Medicare and Medicaid Services for the authority to conduct and act on eligibility redeterminations for each individual enrolled during the period of restrictions enrolled for three (3) or more total months and shall, within sixty (60) days of approval, conduct and act on the redeterminations;

(C) Carry out an additional check of all verification measures required in this subchapter to verify eligibility and act on the information checked; and

(D) Submit a summary report of the audit to the President Pro Tempore of the Senate and Speaker of the House of Representatives; and

(2) Continue to conduct redeterminations as in the normal course of business and act on such redeterminations to the fullest extent permissible under the law.

20-77-2106. Limitation on presumptive eligibility.

(a)(1) The Department of Human Services shall request federal approval from the Centers for Medicare and Medicaid Services for a section 1115 demonstration waiver to enable the department to eliminate mandatory hospital presumptive eligibility and restrict presumptive eligibility determinations to children and pregnant women eligibility groups.

(2) The department shall submit to the Centers for Medicare and Medicaid Services all waiver requests necessary no later than January 1, 2022.

(b) Unless required under federal law, the department shall not designate itself as a qualified health entity for purpose of making presumptive eligibility determinations or for any purpose not expressly authorized by state law.

(c) In making presumptive eligibility determinations, a hospital shall:

(1) Notify the department of each presumptive eligibility determination within five (5) working days from the date the determination was made;

(2) Assist individuals determined to be presumptively eligible with completing and submitting a full Medicaid application form; and

(3) Notify the applicant:

(A) In writing and on all relevant forms with plain language and large print that if the applicant does not file a full Medicaid application with the department before the last day of the following month, presumptive eligibility coverage will end on that last day; and

(B) That if the applicant files a full Medicaid application with the department before the last day of the following month, presumptive eligibility coverage will continue until an eligibility determination is made on the application that was filed.

(d)(1) The department shall use the following standards to establish and ensure accurate presumptive eligibility determinations made by each qualified hospital:

(A) Was the Medicaid Presumptive Eligibility Card, also known as a "HPE-Card", received by the department within five (5) working days from the determination date?;

(B) Was a full Medicaid application received by the department before the expiration of the presumptive eligibility period; and

(C) If a full application was received, was the individual found to be eligible for full Medicaid coverage.

(2)(A) If a qualified hospital fails to meet any of the standards established for any presumptive eligibility determination made by the hospital, the department shall notify the hospital in writing within five (5) days from when the standard was not met.

(B) For the first failure, the written notice shall include:

(i) A description of the standard that was not met and an explanation of why the standard was not met; and

(ii) Confirmation that a second finding of a failure to meet standards shall require that all applicable hospital staff participate in mandatory training on hospital presumptive eligibility rules to be conducted by the department.

(C) For the second failure, the written notice shall include:

(i) A description of the standard that was not met

and an explanation of why the standard was not met;

(ii) Confirmation that all applicable hospital staff are required to participate in a mandatory training on hospital presumptive eligibility rules to be conducted by the department, including the date, time and location of the training as determined by the department;

(iii) A description of available appellate procedures by which a qualified hospital may dispute the finding of failure and remove the finding by providing clear and convincing evidence that the standard was met; and

(iv) Confirmation that if the hospital again fails to meet the standards for presumptive eligibility for any determination, the hospital shall not be qualified to make presumptive eligibility determinations.

(D) For the third failure, the written notice shall include:

(i) A description of the standard that was not met and an explanation of why the standard was not met;

(ii) A description of available appellate procedures by which a qualified hospital may dispute the finding of the failure to meet standards and clear the finding by providing clear and convincing evidence that the standard was met; and

(iii) Confirmation that, effective immediately, the hospital is no longer qualified to make presumptive eligibility determinations of any kind.