State of Arkansas
95th General Assembly
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A Bill

HOUSE BILL 1969

By: Representatives L. Johnson, Achor
By: Senator J. Boyd

For An Act To Be Entitled

AN ACT TO IMPROVE THE QUALITY OF HEALTHCARE ACCESS IN THIS STATE; TO AMEND THE LAW CONCERNING ASSESSMENT FEES ON HOSPITALS; TO CREATE THE HOSPITAL DIRECTED PAYMENT ASSESSMENT; TO CREATE THE GRADUATE MEDICAL EDUCATION EXPANSION PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

TO IMPROVE THE QUALITY OF HEALTHCARE ACCESS; TO AMEND THE ASSESSMENT FEES ON HOSPITALS; AND TO CREATE THE HOSPITAL DIRECTED PAYMENT ASSESSMENT.

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

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

20-77-154. Graduate Medical Education Expansion Account — Graduate Medical Education Expansion Program.

(a) There is created within the Arkansas Medicaid Program Trust Fund a designated account known as the "Graduate Medical Education Expansion Account".

(b) Moneys in the Graduate Medical Education Expansion Account shall consist of all moneys collected or received by the Division of Medical Services from § 26-57-610(b)(6)(B)(ii).

(c) The Graduate Medical Education Expansion Account shall be separate and distinct from the General Revenue Fund Account of the State Apportionment Fund and shall be supplementary to the Arkansas Medicaid Program Trust Fund.

(d) Moneys in the Graduate Medical Education Expansion Account shall supplement, but not supplant, funding appropriated to the Graduate Medical Education Fund under § 19-5-1265.

(e) The Graduate Medical Education Expansion Account shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues.

(f) The moneys in the Graduate Medical Education Expansion Account shall be used only to make payments to eligible hospital providers for the direct costs of graduate medical education programs for eligible residency and fellowship positions added on or after July 1, 2025.

(g) The Graduate Medical Education Expansion Account shall retain account balances remaining at the end of each year.

(h) The division shall promulgate rules to create and implement the "Graduate Medical Education Expansion Program" to provide payments to eligible hospital providers.

SECTION 2. Arkansas Code § 20-77-1901(3), concerning the definition of "Medicare Cost Report" relating to the assessment fee on hospitals participating in the Arkansas Medicaid Program, is amended to read as follows:

(3) "Medicare Cost Report" means ~~CMS-2552-96, the Cost report for Electronic Filing of Hospitals as it existed on January 1, 2009~~ CMS-2552-10, as existing on January 1, 2025;

SECTION 3. Arkansas Code § 20-77-1901(9) and (10), concerning the definitions for upper payment limit and upper payment limit gap, are amended to read as follows:

(9) "Upper payment limit" means the maximum ceiling imposed by federal regulation on privately owned hospital fee-for-service Medicaid reimbursement for inpatient services under 42 C.F.R § 447.272 and outpatient services under 42 C.F.R § 447.321; and

(10)(A) "Upper payment limit gap" means the difference between the upper payment limit and fee-for-service Medicaid payments not financed using hospital assessments made to all privately operated hospitals.

(B) The upper payment limit gap shall be calculated separately for hospital inpatient and fee-for-service outpatient services.

(C) Medicaid disproportionate share payments shall be excluded from the calculation of the upper payment limit gap.

SECTION 4. Arkansas Code Title 20, Chapter 77 is amended to add an additional subchapter to read as follows:

Subchapter 29 — Hospital Directed Payment Assessment

20-77-2901. Purpose.

The purpose of this subchapter is to:

(1) Maximize reimbursement for hospital services to Medicaid patients in this state;

(2) Ensure the financial sustainability of healthcare in this state, including in rural areas; and

(3) Support access and quality of care for residents of this state.

20-77-2902. Definitions.

As used in this subchapter:

(1) "Contract year" means the capitation rating period of January 1 through December 31 of each year in which a contracted entity enters into a capitated contract with the Department of Human Services under the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq., or any other Medicaid managed care programs for which the Department of Human Services contracts;

(2)(A) "Contracted entity" means an organization or entity that enters into or will enter into a capitated contract with the Department of Human Services for the delivery of services under the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq., or any successor Medicaid managed care program, that will assume financial risk, operational accountability, and statewide or regional functionality in managing comprehensive health outcomes of Medicaid beneficiaries.

(B) "Contracted entity" includes without limitation an accountable care organization, a risk-based provider organization, a provider-led entity, a commercial plan, a dental benefit manager, a managed care organization, or any other entity as determined by the Department of Human Services;

(3) "Directed payment" means payment arrangements under 42 C.F.R. § 438.6(c), as existing on January 1, 2025, that permit states to direct specific payments made by contracted entities to providers under certain circumstances and can assist states in furthering the goals and priorities of Medicaid managed care programs;

(4) "Directed payment preprint" means the materials required under 42 C.F.R. § 438.6(c), as existing on January 1, 2025, to be submitted to the Centers for Medicare & Medicaid Services for review and written approval prior to implementing directed payments;

(5) "Hospital" means a healthcare facility licensed as a hospital by the Department of Health under § 20-9-213;

(6)(A) "Managed care gap" means the difference between:

(i) The maximum amount that can be paid for hospital inpatient and outpatient services to Medicaid managed care enrollees; and

(ii) The total amount of Medicaid managed care payments for hospital inpatient and outpatient services.

(B) In calculating the managed care gap, the Department of Human Services shall use whatever methodology and data source permitted under 42 C.F.R. § 438.6(c)(2)(ii) and (iii), as existing on January 1, 2025, that would result in the highest payment rate for hospital services under § 20-77-2910;

(7) "Managed care program" means a Medicaid managed care delivery system operated under a contract between the Department of Human Services and a contracted entity as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act;

(8) "Medicare cost report" means CMS-2552-10, the Hospital and Hospital Health Care Complex Cost Report, or the cost report for electronic filing of hospitals;

(9) "Pass-through payment" means a managed care program payment arrangement implemented in accordance with 42 C.F.R. § 438.6(d)(6), as existing on January 1, 2025, for services transitioned from a fee-for-service program to a managed care program on or after January 1, 2026, for the purposes of ensuring that payments to individual hospitals are not adversely affected by transition of services to managed care programs; and

(10) "State government-owned hospital" means a hospital that is owned by an agency or unit of state government, including the University of

Arkansas for Medical Sciences.

20-77-2903. Hospital managed care reimbursement.

On and after January 1, 2026, the Division of Medical Services of the Department of Human Services shall ensure that all hospital services to Medicaid managed care program enrollees be reimbursed at the highest rate permitted by federal law through the implementation of directed payments programs and other mechanisms authorized by this subchapter.

20-77-2904. Hospital directed payment assessment.

(a) There is created the hospital directed payment assessment, which shall be a directed payment assessment imposed on each hospital, except those exempted by the Division of Medical Services under the authority in § 20-77-2907, for each contract year in accordance with rules adopted by the division.

(b) The hospital directed payment assessment rates under subsection (a) of this section shall be determined annually to generate the non-federal portion of the managed care gap plus the annual fee under § 20-77-2906(f)(1)(C), but in no case at rates that would cause the combined assessment proceeds under this subchapter and § 20-77-1902 to exceed the indirect guarantee threshold set forth in 42 C.F.R. § 433.68(f)(3)(i), as existing on January 1, 2025.

(c)(1) The assessment basis under this section shall be adopted by rule and calculated using the data from each hospital's most recent audited Medicare cost report available at the time of the calculation, including data for hospitals assessed under this section and hospitals exempted from the assessment under § 20-77-2907.

(2) The inpatient and outpatient portions of assessment basis under this subsection shall be determined through methods adopted by rule.

(d) This subchapter does not authorize a unit of county or local government to license for revenue or impose a tax or assessment upon hospitals or a tax or assessment measured by the income or earnings of a hospital.

20-77-2905. Hospital directed payment assessment administration.

(a) The Director of the Division of Medical Services shall administer

the hospital directed payment assessment created in this subchapter.

(b)(1) The Division of Medical Services shall adopt rules to implement this subchapter.

(2) The rules adopted under this section shall specify any exceptions to or exemptions from the hospital directed payment assessment in accordance with authorities in § 20-77-2907.

(3) The rules adopted under this section shall include any necessary forms for:

(A) Proper imposition and collection of the hospital directed payment assessment imposed under § 20-77-2904;

(B) Enforcement of this subchapter, including without limitation letters of caution or sanctions; and

(C) Reporting of inpatient and outpatient portions of the assessment basis.

(c) To the extent practicable, the division shall administer and enforce this subchapter and collect the assessments, interest, and penalty assessments imposed under this subchapter using procedures generally employed in the administration of the division's other powers, duties, and functions.

20-77-2906. Hospital Directed Payment Assessment Account.

(a)(1) There is created within the Arkansas Medicaid Program Trust Fund a designated account known as the "Hospital Directed Payment Assessment Account".

(2) The hospital directed payment assessments imposed under § 20-77-2904 shall be deposited into the Hospital Directed Payment Assessment Account.

(b) Moneys in the Hospital Directed Payment Assessment Account shall consist of:

(1) All moneys collected or received by the Division of Medical Services from hospital directed payment program assessments under § 20-77-2904; and

(2) Any interest or penalties levied in conjunction with the administration of this subchapter.

(c) The Hospital Directed Payment Assessment Account shall be separate and distinct from the General Revenue Fund Account of the State Apportionment Fund and shall be supplementary to the Arkansas Medicaid Program Trust Fund.

(d) Moneys in the Hospital Directed Payment Assessment Account shall not be used to:

(1) Replace any general revenues appropriated and funded by the General Assembly or other revenues used to support Medicaid, including appropriations for cost settlements and other payments that may be reduced or eliminated as a result of any transition of populations or services to Medicaid managed care;

(2) Reduce hospital payment rates under the Arkansas Medicaid Program, including negotiated rates paid by contracted entities, below the hospital rates in effect on the date on the effective date of this subchapter; or

(3)(A) Fund directed payments for state government-owned hospitals.

(B) A state government-owned hospital may separately fund directed payments through intergovernmental transfers.

(e) The Hospital Directed Payment Assessment Account shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues.

(f)(1) Except as necessary to reimburse any funds borrowed to supplement funds in the Hospital Directed Payment Assessment Account, the moneys in the Hospital Directed Payment Assessment Account shall be used only to:

(A) Make inpatient and outpatient hospital directed payments under § 20-77-2910;

(B) Reimburse moneys collected by the division from hospitals through error or mistake or under this subchapter;

(C) Pay an annual fee to the division in the amount of three and three-quarters percent (3.75%) of the assessments collected from hospitals under § 20-77-2904 each contract year; or

(D) Make hospital pass-through payments under § 20-77-2911, in amounts deemed necessary by the division, to ensure Medicaid payments to individual hospitals are not adversely impacted by transitioning delivery of services from fee-for-service programs to managed care programs on and after January 1, 2026.

(2)(A) The Hospital Directed Payment Assessment Account shall retain account balances remaining at the end of each contract year.

(B) At the end of each contract year, any positive balance remaining in the Hospital Directed Payment Assessment Account shall be factored into the calculation of the new assessment rate by reducing the amount of hospital directed payment assessment funds that must be generated during the subsequent contract year.

(3) A hospital shall not be guaranteed that its inpatient and outpatient hospital directed payment access payments will equal or exceed the amount of its hospital directed payment assessment.

20-77-2907. Exemptions.

(a) The Division of Medical Services may establish hospital assessment exemptions or varied assessment rates as needed to effectuate the purpose of the hospital directed payment assessment as established in this subchapter.

(b) In addition to any exemptions established in accordance with subsection (a) of this section, the division shall exempt from the hospital directed payment assessment under § 20-77-2904 any state government-owned hospital.

20-77-2908. Quarterly notice and collection.

(a)(1) The annual hospital directed payment assessment imposed under § 20-77-2904 shall be due and payable on a quarterly basis.

(2) However, an installment payment of a hospital directed payment assessment imposed by § 20-77-2904 shall not be due and payable until:

(A) The Division of Medical Services issues the written notice required by § 20-77-2909 stating that the payment methodologies to hospitals required under § 20-77-2910 have been approved by the Centers for Medicare & Medicaid Services and the waiver under 42 C.F.R. § 433.68 for the hospital directed payment assessment imposed by § 20-77-2904, if necessary, has been granted by the Centers for Medicare & Medicaid Services;

(B) The thirty-day verification period required by § 20-77-2909(b) has expired; and

(C) The division has made all quarterly installments of inpatient and outpatient hospital directed payment access payments to contracted entities that were otherwise due under § 20-77-2910 consistent with the effective date of the approved directed payment preprint and waiver.

(3) After the initial installment has been paid under this section, each subsequent quarterly installment payment of the hospital directed payment assessment imposed by § 20-77-2904 shall be due and payable within ten (10) business days after the hospital has received its inpatient and outpatient hospital directed payment access payments due under § 20-77-2910 for the applicable quarter.

(b) The payment by the hospital of the hospital directed payment assessment created in this subchapter shall be reported as an allowable cost for Medicaid reimbursement purposes.

(c)(1) If a hospital fails to timely pay the full amount of a quarterly hospital directed payment assessment, the division may add to the assessment:

(A) A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date; and

(B) On the last day of each quarter after the due date until the assessed amount and the penalty imposed under subsection (c)(1)(A) of this section are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(2) Payments shall be credited first to unpaid quarterly amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

(3) If the division is unable to recoup from Medicaid payments the full amount of any unpaid hospital directed payment assessment or penalty assessment, or both, the division may file suit in a court of competent jurisdiction to collect up to double the amount due, the division's costs related to the suit, and reasonable attorney's fees.

20-77-2909. Notice of hospital directed payment assessment.

(a)(1) The Division of Medical Services shall send a notice of hospital directed payment assessment to each hospital informing the hospital of the hospital directed payment assessment rate, the hospital's assessment basis calculation, and the estimated hospital directed payment assessment amount owed by the hospital for the applicable contract year.

(2) Except as set forth in subdivision (a)(3) of this section, the annual notices of hospital directed payment assessment under subdivision (a)(1) of this section shall be sent at least forty-five (45) days before the

due date for the first quarterly hospital directed payment assessment payment of each contract year.

(3) The first notice of the hospital directed payment assessment under subdivision (a)(1) of this section shall be sent within fifteen (15) days after receipt by the division of notification from the Centers for Medicare & Medicaid Services for the payments required under § 20-77-2910 and, if necessary, the waiver granted under 42 C.F.R. § 433.68 have been approved.

(b) The hospital shall have thirty (30) days from the date of its receipt of a notice of the hospital directed payment assessment under subdivision (a)(1) of this section to review and verify the hospital directed payment assessment rate, the hospital's assessment basis calculation, and the hospital directed payment assessment amount.

(c)(1) If a hospital provider operates, conducts, or maintains more than one (1) hospital in the state, the hospital provider shall pay the hospital directed payment assessment rate for each hospital separately.

(2) However, if the hospital provider under subdivision (c)(1) of this section operates more than one (1) hospital under one (1) Medicaid provider number, the hospital provider may pay the hospital directed payment assessment for the hospitals in the aggregate.

(d)(1) For a hospital subject to the hospital directed payment assessment under § 20-77-2904 that ceases to conduct hospital operations or maintain its state license or did not conduct hospital operations throughout a contract year, the hospital directed payment assessment for the contract year in which the cessation occurs shall be adjudicated by multiplying the annual hospital directed payment assessment computed under § 20-77-2904 by a fraction, the numerator of which is the number of days during the year that the hospital operated and the denominator of which is three hundred sixty-five (365).

(2)(A) Immediately upon ceasing to operate, the hospital shall pay the adjusted hospital directed payment assessment for that contract year to the extent not previously paid.

(B) The hospital also shall receive payments under § 20-77-2910 for the contract year in which the cessation occurs, which shall be adjusted by the same fraction as its annual hospital directed payment assessment.

(e) A hospital subject to a hospital directed payment assessment under this subchapter that has not been previously licensed as a hospital in Arkansas and that commences hospital operations during a contract year shall pay the required hospital directed payment assessment computed under § 20-77-2904 and shall be eligible for hospital directed payment access payments under § 20-77-2910 on the date specified in rules promulgated by the division under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(f) A hospital that is exempt from payment of the hospital directed payment assessment under § 20-77-2907 at the beginning of a contract year but during the contract year experiences a change in status so that it becomes subject to a hospital directed payment assessment shall pay the required hospital directed payment assessment computed under § 20-77-2904 and shall be eligible for hospital directed payment access payments under § 20-77-2910 on the date specified in rules promulgated by the division.

(g) A hospital that is subject to payment of the hospital directed payment assessment computed under § 20-77-2904 at the beginning of a contract year but during the contract year experiences a change in status so that it becomes exempted from payment under § 20-77-2907 shall be relieved of its obligation to pay the hospital directed payment assessment and shall become ineligible for hospital directed payment access payments under § 20-77-2910 on the date specified in rules promulgated by the division.

20-77-2910. Hospital directed payment access payments.

(a) To preserve and improve access to quality hospital services, for hospital inpatient and outpatient services rendered on or after January 1, 2026, the Division of Medical Services shall make hospital directed payment access payments as set forth in this section.

(b) The division shall calculate the total hospital directed payment access payment amount as the lesser of:

(1) The amount equal to the managed care gap for inpatient and outpatient hospital services; or

(2) The amount that can be financed with a level of non-federal funds generated through hospital directed payment assessments imposed under § 20-77-2904 that causes the combined assessment proceeds under § 20-77-1902 and § 20-77-2904 to equal the indirect guarantee threshold set forth in 42 C.F.R. § 433.68(f)(3)(i), as existing on January 1, 2025.

(c)(1) All hospitals shall be eligible for inpatient and outpatient hospital directed payment access payments through contracted entities each contract year as set forth in this subsection other than state government-owned hospitals.

(2)(A) A portion of the hospital directed payment access payment amount, not to exceed the managed care gap for inpatient services, shall be designated as the inpatient hospital directed payment access payment pool.

(B) Inpatient hospital directed payment access payments shall be paid as a uniform percentage rate increase or uniform add-on to base Medicaid managed care reimbursement to eligible hospitals.

(3)(A) A portion of the hospital directed payment access payment amount, not to exceed the managed care gap for outpatient hospital services, shall be designated as the outpatient hospital directed payment access payment pool.

(B) Outpatient hospital directed payment access payments shall be paid as a uniform percentage rate increase or uniform add-on to base Medicaid managed care reimbursement to eligible hospitals.

(4)(A) The hospital directed payment access payment shall be administered through a separate payment term and lump-sum payments that are paid no later than thirty (30) days after the end of each quarter for which the lump-sum payment is attributable, provided that the Centers for Medicare & Medicaid Services permit the use of this payment mechanism.

(B)(i) In the event that the Centers for Medicare & Medicaid Services does not permit use of a separate payment term and lump-sum payments under subdivision (c)(4)(A) of this section, the division shall include directed payments in capitation rates and require contracted entities to make add-on payments in hospital claims.

(ii) The division shall require contracted entities to clearly delineate for hospitals the portion of reimbursement attributable to directed payments from the portion of reimbursement paid at negotiated rates.

(d) A hospital directed payment access payment shall not be used to offset any other payment by contracted entities for hospital inpatient or outpatient services to Medicaid managed care beneficiaries, including without limitation any fee-for-service, per diem, private hospital inpatient adjustment, Medicaid managed care, or cost-settlement payment.

20-77-2911. Managed Care Pass-Through Payment Pool Account.

(a) There is created within the Arkansas Medicaid Program Trust Fund a designated account known as the "Managed Care Pass-Through Payment Pool Account".

(b) Moneys in the Managed Care Pass-Through Payment Pool Account shall consist of all moneys collected or received by the Division of Medical Services under § 20-77-2906(f)(1)(D).

(c) The Managed Care Pass-Through Payment Pool Account shall be separate and distinct from the General Revenue Fund Account of the State Apportionment Fund and shall be supplementary to the Arkansas Medicaid Program Trust Fund.

(d) Moneys in the Managed Care Pass-Through Payment Pool Account shall not be used to:

(1) Replace any general revenues appropriated and funded by the General Assembly or other revenues used to support Medicaid, including appropriations for cost settlements and other payments that may be reduced or eliminated as a result of any transition of populations or services to managed care;

(2) Reduce provider payment rates under the Arkansas Medicaid Program, including negotiated rates paid by contracted entities, below the provider payment rates in effect on the effective date of this subchapter; or

(3)(A) Fund managed care pass-through payments for state government-owned hospitals.

(B) A state government-owned hospital may separately fund managed care pass-through payments through intergovernmental transfers.

(e) The Managed Care Pass-Through Payment Pool Account shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues or special revenues allocated for Medicaid.

(f)(1) Except as necessary to reimburse any funds borrowed to supplement funds in the Hospital Directed Payment Assessment Account, the moneys in the Managed Care Pass-Through Payment Pool Account shall be used only to:

(A) Make pass-through payments to individual hospitals, as deemed necessary by the Department of Human Services, to ensure payments to individual hospitals are not adversely impacted by the transition of any

services from fee-for-service programs to managed care programs, on and after January 1, 2026; or

(B) Reimburse moneys collected by the division from hospitals through error or mistake under this subchapter.

(2) The Managed Care Pass-Through Payment Pool Account shall retain all account balances at the end of each contract year.

20-77-2912. Managed Care Provider Incentive Pool Account.

(a) There is created within the Arkansas Medicaid Program Trust Fund a designated account known as the "Managed Care Provider Incentive Pool Account".

(b) Moneys in the Managed Care Provider Incentive Pool Account shall consist of all moneys collected or received by the Division of Medical Services from § 26-57-610(b)(6)(B)(i).

(c) The Managed Care Provider Incentive Pool Account shall be separate and distinct from the General Revenue Fund Account of the State Apportionment Fund and shall be supplementary to the Arkansas Medicaid Program Trust Fund.

(d) Moneys in the Managed Care Provider Incentive Pool Account shall not be used to:

(1) Replace any general revenues appropriated and funded by the General Assembly or other revenues used to support Medicaid, including appropriations for cost settlements and other payments that may be reduced or eliminated as a result of any transition of populations or services to managed care;

(2) Reduce provider payment rates under the Arkansas Medicaid Program, including negotiated rates paid by contracted entities, below the provider payment rates in effect on the effective date of this subchapter; or

(3)(A) Fund managed care provider incentive pool payments for state government-owned hospitals.

(B) A state government-owned hospital may separately fund managed care provider incentive pool payments through intergovernmental transfers.

(e) The Managed Care Provider Incentive Pool Account shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues.

(f)(1) Except as necessary to reimburse any funds borrowed to

supplement funds in the Hospital Directed Payment Assessment Account, the moneys in the Managed Care Provider Incentive Pool Account shall be used only to:

(A) Make incentive payments to Medicaid providers to improve access and quality of care under § 20-77-2914; or

(B) Reimburse moneys collected by the division from hospitals through error or mistake or under this subchapter.

(2) The Managed Care Provider Incentive Pool Account shall retain account balances remaining at the end of each contract year.

20-77-2913. Medicaid Sustainability Advisory Committee — Medicaid Quality Advisory Committee.

(a) To ensure providers have a voice in the direction and operation of the Medicaid programs contemplated by this subchapter, the Division of Medical Services shall establish a Medicaid Sustainability Advisory Committee and the Medicaid Quality Advisory Committee.

(b)(1) The Medicaid Sustainability Advisory Committee shall be comprised of:

(A) Two (2) members appointed by the division;

(B) Four (4) members appointed by hospitals and integrated health systems;

(C) One (1) member appointed by the University of Arkansas for Medical Sciences;

(D) One (1) member appointed by the Arkansas Hospital Association, Inc.; and

(E) Two (2) other representatives of the healthcare provider community.

(2) The Medicaid Sustainability Advisory Committee shall make recommendations to the division and the General Assembly regarding any proposed legislative, programmatic, regulatory, or policy change that impacts hospitals' participation in directed payments, pass-through payments, hospital assessments, graduate medical education, provider incentives, and managed care programs.

(c)(1) The Medicaid Quality Advisory Committee shall be comprised of:

(A) Two (2) members appointed by the division;

(B) Four (4) members appointed by hospitals and integrated

health systems;

(C) One (1) member appointed by University of Arkansas for Medical Sciences; and

(D) Two (2) other representatives of the healthcare provider community.

(2) The Medicaid Quality Advisory Committee shall review quality improvement needs and recommend initiatives supported by the Managed Care Provider Incentive Program.

20-77-2914. Managed Care Provider Incentive Program.

(a)(1) The Division of Medical Services shall promulgate rules to create and implement the "Managed Care Provider Incentive Program" to support healthcare quality assurance and access improvement initiatives.

(2) For state fiscal years ending on or before June 30, 2030, the Managed Care Provider Incentive Program shall be dedicated to initiatives that support improved access to maternal health and primary care providers.

(3) For state fiscal years starting on or after July 1, 2030, the Managed Care Provider Incentive Program shall be dedicated to other initiatives approved by a majority vote of the Medicaid Sustainability Advisory Committee.

(b) For state fiscal years starting on or after July 1, 2030, all initiatives supported by the Managed Care Provider Incentive Program shall be approved by a majority vote of the members of the Medicaid Quality Advisory Committee.

20-77-2915. Processing directed payments through contracted entities.

The Division of Medical Services may process directed payments through contracted entities only if:

(1) The division provides each contracted entity with a detailed list of hospital directed payment access payments, specifying the amounts to be paid to each eligible hospital as required by this subchapter;

(2) Each contracted entity disburses the hospital directed payment access payments to eligible hospitals within five (5) business days of receiving a supplemental capitation payment;

(3) Contracted entities are prohibited from withholding or delaying the payment of a hospital directed payment access payment for any

reason; and

(4) The division exercises administrative discretion to ensure that each eligible hospital receives the full payment of all hospital directed payment access payments, utilizing appropriate payment mechanisms as necessary.

20-77-2916. Effectiveness and cessation.

(a) The hospital directed payment assessment imposed under § 20-77-2904 shall cease to be imposed, the Medicaid hospital directed payment access payments made under § 20-77-2910 shall cease to be paid, and any moneys remaining in the Hospital Directed Payment Assessment Account and the Managed Care Provider Incentive Pool Account that were derived from the hospital directed payment assessment imposed under § 20-77-2904 shall be refunded to hospitals in proportion to the amounts paid by the hospitals if the inpatient or outpatient hospital directed payment access payments required under § 20-77-2910 are not approved or the hospital directed payments assessments imposed under § 20-77-2904 are not eligible for federal matching funds under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq.

(b)(1) The hospital directed payment assessment imposed under § 20-77-2904 shall cease to be imposed and the hospital directed payment access payments under § 20-77-2910 shall cease to be paid if the assessment is determined to be impermissible under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.

(2) Moneys in the Hospital Directed Payment Assessment Account in the Arkansas Medicaid Program Trust Fund derived from assessments imposed before the determination described in subdivision (b)(1) of this section shall be disbursed under § 20-77-2910 to the extent federal matching is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospitals in proportion to the amounts paid by the hospitals.

20-77-2917. Directed payment preprint.

(a)(1) The Division of Medical Services shall seek approval of the hospital directed payment access payments under § 20-77-2910 from the Centers for Medicare & Medicaid Services for each contract year by submitting a

directed payment preprint and any information required under 42 C.F.R.§ 438.6(c) to the Centers for Medicare & Medicaid Services at least ninety (90) days before the start of each contract year.

(2) The division shall prepare the annual 42 C.F.R. § 438.6(c) directed payment preprint or amendment in collaboration with the Arkansas Hospital Association, Inc.

(3) To the extent the directed payment preprint or amendment that the division plans to submit to the Centers for Medicare & Medicaid Services for approval would result in a reduction to the payment rate to eligible hospitals as compared to the federally approved rates for the prior year or directed payment preprint submission, the division shall provide the Medicaid Sustainability Advisory Committee at least thirty (30) days to review and propose an alternative methodology.

(4) The division shall use the methodology proposed by the Medicaid Sustainability Advisory Committee for the directed payment preprint submission unless the division obtains written confirmation from the Centers for Medicare & Medicaid Services that the proposed alternative methodology cannot be approved as proposed and that no modifications are possible to obtain approval for the alternative methodology.

(5) The division shall make the written confirmation available to the Medicaid Sustainability Advisory Committee.

(b)(1) The directed payment preprint shall not condition hospital eligibility for directed payments upon hospital compliance with initiatives and policies that are not related to quality measures identified in the Medicaid managed care quality strategy or otherwise require hospitals to spend a portion of their directed payment or other revenues as prescribed by the division to remain eligible for directed payments.

(2) All inpatient and outpatient hospital services paid by contracted entities for services shall be eligible for the directed payment, regardless of whether the hospital is in-network with the contracted entity.

(c) If the directed payment preprint is not approved by the Centers for Medicare & Medicaid Services, the division shall:

(1) Not implement the hospital directed payment assessment imposed under § 20-77-2904; and

(2) Return any hospital directed payment assessment fees to the hospitals that paid the fees if hospital directed payment assessment fees

have been collected.

20-77-2918. Continuation of hospital access payments.

The Department of Human Services shall continue to pay the maximum upper payment limit hospital access payments for inpatient and outpatient hospital services delivered to fee-for-service Medicaid populations to the full extent authorized under § 20-77-1901 et seq., until Medicaid populations or program services are transferred from a fee-for-service to a managed care delivery model.

SECTION 5. Arkansas Code § 26-57-610(b), concerning the disposition of insurance premium taxes, is amended to add an additional subdivision to read as follows:

(6) The taxes based on premiums collected under the Arkansas Medicaid Program, other than the premiums collected for coverage under subdivisions (b)(2) and (b)(5) of this section at the levels of coverage that existed as of January 1, 2025, shall be:

(A) At the time of deposit, separately certified by the commissioner to the Treasurer of State for classification and distribution under this section; and

(B) Transferred in amounts equal to:

(i) Fifty percent (50%) of the taxes for deposit into the Managed Care Provider Incentive Pool Account under § 20-77-2912;

(ii) Ten percent (10%) of the taxes for deposit into the Graduate Medical Education Expansion Account set forth in § 20-77-154; and

(iii) Forty percent (40%) of the taxes for deposit into the General Revenue Fund Account to be used in a manner authorized by the General Assembly for the purposes set forth in the Revenue Stabilization Law, § 19-5-101 et seq.

SECTION 6. DO NOT CODIFY. Contingent effective date.

Sections 1, 4, and 5 of this act are effective on and after the date that the Secretary of the Department of Human Services:

(1) Determines that the:

(1) Fee-for-service Medicaid populations are added as a

covered populations to be served by a risk-based provider organization under the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq.;

(2) Fee-for-service Medicaid populations are transitioned to a Medicaid managed care program approved by the Centers for Medicare & Medicaid Services;

(3) Individuals in the eligibility category created by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a, as existing on January 1, 2025, are transitioned to a Medicaid managed care program approved by the Centers for Medicare & Medicaid Services; or

(4) Individuals in the eligibility category created by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a, as existing on January 1, 2025, are transitioned to a risk-based provider organization under the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq.; and

(2) Notifies the Legislative Council and the Director of the Bureau of Legislative Research that one (1) of the contingencies listed in subdivision (1) of this section has occurred.