DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Life360 State Plan Amendment: Targeted Case Management

DESCRIPTION:

Statement of Necessity

DHS amends its fee-for-service Medicaid State Plan to include the Life360 HOMES services under the Arkansas Health and Opportunity for ME (ARHOME) program. The Life360 HOMES Medicaid Provider Manual, effective November 1, 2023, established services to be provided by eligible Arkansas Medicaid-enrolled hospitals to ensure clients in target populations are connected to medical services and nonmedical supports in their communities to address their health-related social needs (HRSN) through intensive care coordination.

This rule conforms the Medicaid State Plan to the Life360 program. The amendment to the plan provides a targeted case management benefit to Medicaid eligible pregnant women with intensive care coordination services. The benefit ensures these beneficiaries have an opportunity to connect to medical services and nonmedical supports in their communities and to address their social determinants of health (SDOH) needs. Approval of the state plan amendment (SPA) by the Centers for Medicare and Medicaid (CMS) is necessary for targeted case management of high-risk pregnant women who are eligible for traditional fee for service Medicaid. These services will:

- Reduce the maternal and infant mortality rates in the state and reduce long-term costs;
- Reduce the additional risk for disease and premature death associated with living in a rural county;
- Strengthen financial stability of small, rural hospitals, and enhance access to medical services in rural counties;
- Fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;
- Increase their engagement in educational and employment opportunities among Medicaid beneficiaries most at risk for poor health outcomes associated with poverty;
- Reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings; and
- Increase the use of preventative care and health screenings.

Summary

To achieve the above, the Division of Medical Services amended the Medicaid State Plan to provide women with high-risk pregnancies who are eligible for Medicaid but are not in the New Adult Medicaid Expansion Group the opportunity to receive home-visiting services through the Life360 HOMES program. The amendment allows for hospitals approved to provide Maternal Life360 HOMES services to receive $300 per member per

month for women enrolled in the Maternal Life 360 HOMES program through fee for service traditional Medicaid. The SPA conforms to the recently promulgated Life360HOMES provider manual.

PUBLIC COMMENT: A public hearing was held on this rule on July 17, 2024. The public comment period expired on August 3, 2024. The agency indicated that it received no comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The agency indicated that this rule has no financial impact.

LEGAL AUTHORIZATION: The Department of Human Services shall administer the Arkansas Health and Opportunity for Me Program "as approved by the Centers for Medicare and Medicaid Services." Ark. Code Ann. § 23-61-1004(a)(1)(B)(ii). The Department shall adopt rules necessary to implement Title 23, Chapter 61, Subchapter 10 of the Arkansas Code, regarding the Arkansas Health and Opportunity for Me Act of 2021. Ark. Code Ann. § 23-61-1012. The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

Office of Policy and Rules
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
P: 501.320.6383 F: 501.404.4619

July 3, 2024

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Life360 State Plan Amendment: Targeted Case Management

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Deputy Chief

Attachments

QUESTIONNAIRE FOR FILING PROPOSED RULES WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Medical Services
BOARD/COMMISSION DIRECTOR Elizabeth Pitman
CONTACT PERSON Mac Golden
ADDRESS P. O. Box 1437, Slot S295 Little Rock, AR 72203-1437
PHONE NO. (501) 320-6383 **EMAIL** Mac.E.Golden @dhs.arkansas.gov
NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING
Elizabeth Pitman
PRESENTER EMAIL(S) Elizabeth.Pitman@dhs.arkansas.gov

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

****

1. What is the official title of this rule?
Life360 State Plan Amendment: Targeted Case Management

2. What is the subject of the proposed rule? Fee for Service TCM of pregnant women's services

3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☑

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☐

4. Is this rule being filed for permanent promulgation? Yes ☑ No ☐

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☑

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire?_____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes ☐ No ☑

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes ☐ No ☑

If yes, please provide the state statute and/or rule citation.

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes ☐ No ☑

If yes, please list the rules being repealed.
If no, please explain.

Governor's Exception

8. Is this a new rule? Yes ☐ No ☑

Does this repeal an existing rule? Yes ☐ No ☑
If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes ☑ No ☐
If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

Arkansas Code §§ 20-61-1012, 20-76-201, 20-77-107, 23-61-1004, and 25-10-129

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes ☑ No ☐

If yes, please provide the year of the act(s) and act number(s).

Arkansas Health and Opportunity for ME (ARHOME) Act 530 of 2021

11. What is the reason for this proposed rule? Why is it necessary?

The rule allows Medicaid to provide pregnant women who are eligible under traditional, fee for service Medicaid with targeted case management services through the Life 360 HOME program during their pregnancy and postpartum coverage period.

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

13. Will a public hearing be held on this proposed rule? Yes ☑ No ☐

If yes, please complete the following:

Date: 07/17/2024

Time: 10:00 am

Place: https://us02web.zoom.us/j/83031064218

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. 08/03/2024

15. What is the proposed effective date for this rule? 10/01/2024

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

19. Is the rule expected to be controversial? Yes ☐ No ☑

If yes, please explain.

NOTICE OF RULEMAKING

The Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-61-1012, 20-76-201, 20-77-107, 23-61-1004, and 25-10-129. The anticipated effective date of the rule is October 1, 2024.

The Division of Medical Services (DMS) amends its fee-for-service Medicaid State Plan to include the Life360 HOMES services under the Arkansas Health and Opportunity for ME (ARHOME) program following promulgation of the Life360 HOMES Medicaid Provider Manual November 1, 2023, which established services to be provided by eligible Arkansas Medicaid-enrolled hospitals to ensure clients in target populations are connected to medical services and nonmedical supports in their communities to address their health-related social needs (HRSN) through intensive care coordination. This amendment to the plan provides a targeted case management benefit to Medicaid eligible pregnant women with intensive care coordination services. Those eligible women who are not in the New Adult Medicaid Expansion Group can receive home-visiting services through the Life360 HOMES program. The amendment allows for eligible hospitals to receive $300 per member per month for women enrolled in the Maternal Life 360 HOMES program through fee for service traditional Medicaid. There is no fiscal impact.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov; or, during the public hearing. All public comments must be received by DHS no later than August 3, 2024. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at ar.gov/dhszoom.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at (501) 320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin. 4502201653

Elizabeth Pitman, Director
Division of Medical Services

From: Legal Ads
To: Renita Jones
Subject: Re: Full Run AD - Life360 State Plan Amendment: Targeted Case Management (Rule #275)
Date: Monday, July 1, 2024 3:21:53 PM
Attachments: image001.png
image002.png

[EXTERNAL SENDER]

Will run Fri 7/5, Sat 7/6, and Sun 7/7.

Thank you.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Monday, July 1, 2024 3:09:00 PM
Subject: Full Run AD - Life360 State Plan Amendment: Targeted Case Management (Rule #275)

Good afternoon,

Please run the attached public notice on **Friday, July 5th**, **Saturday, July 6th and Sunday, July 7th**. I am aware that the print version will only be provided to all counties on Sundays. Please let me know if you have any questions or concerns. Please reply to this email using REPLY ALL.

Please invoice to: **AR Dept. of Human Services**
OPR, ATTN: Lakeya Gipson
P.O. Box 1437, Slot S295
Little Rock, AR 72203-8068
(Lakeya.Gipson@dhs.arkansas.gov)

Thank you,

DHS
Renita Jones

Office of Policy & Rules
Program Administrator

P: 501.320.3949
F: 501.404.4619
700 Main St.
Little Rock, AR 72203
Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov

This email may contain sensitive or confidential information.
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From:	Renita Jones
To:	Arkansas Register
Cc:	Renita Jones; Mac Golden; Jack Tiner; JAMIE EWING; Lakeya Gipson
Subject:	DHS/DMS - Proposed Filing - Life360 State Plan Amendment: Targeted Case Management - Rule #275
Date:	Wednesday, July 3, 2024 8:17:00 AM
Attachments:	Initial Filing Sec of State Rule#275.pdf image001.png image002.png

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Good morning,

Please see attached for initial filing. This rule will run in the Arkansas Democrat Gazette on Friday, July 5th, Saturday, July 6th and Sunday, July 7th. The public comment period ends on August 3, 2024. Please let me know if you have any questions.

Thank you,

DHS
Renita Jones
Office of Policy & Rules
Program Administrator

P: 501.320.3949
F: 501.404.4619
700 Main St.
Little Rock, AR 72203
Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov

This email may contain sensitive or confidential information.
CONFIDENTIALITY NOTICE: The information contained in this email message and any attachment(s) is the property of the State of Arkansas and may be protected by state and federal laws governing disclosure of private information. It is intended solely for the use of the entity to which this email is addressed. If you are not the intended recipient, you are hereby notified that reading, copying or distribution this transmission is STRICTLY PROHIBITED. The sender has not waived any applicable privilege by sending the accompanying transmission. If you have received this transmission in error, please notify the sender by return and delete the message and attachment(s) from your system.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Life360 State Plan Amendment, Targeted Case Management

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ☐ No ☑

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes ☑ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☑ No ☐

   If no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0.00	Total	$ 0.00

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$	$

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0.00	$ 0.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☑

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Statement of Necessity and Rule Summary
Life360 State Plan Amendment: Targeted Case Management

Statement of Necessity
DHS amends its fee-for-service Medicaid State Plan to include the Life360 HOMES services under the Arkansas Health and Opportunity for ME (ARHOME) program. The Life360 HOMES Medicaid Provider Manual, effective November 1, 2023, established services to be provided by eligible Arkansas Medicaid-enrolled hospitals to ensure clients in target populations are connected to medical services and nonmedical supports in their communities to address their health-related social needs (HRSN) through intensive care coordination.

This rule conforms the Medicaid State Plan to the Life360 program. The amendment to the plan provides a targeted case management benefit to Medicaid eligible pregnant women with intensive care coordination services. The benefit ensures these beneficiaries have an opportunity to connect to medical services and nonmedical supports in their communities and to address their social determinants of health (SDOH) needs. Approval of the state plan amendment (SPA) by the Centers for Medicare and Medicaid (CMS) is necessary for targeted case management of high-risk pregnant women who are eligible for traditional fee for service Medicaid. These services will:

- Reduce the maternal and infant mortality rates in the state and reduce long-term costs;
- Reduce the additional risk for disease and premature death associated with living in a rural county;
- Strengthen financial stability of small, rural hospitals, and enhance access to medical services in rural counties;
- Fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;
- Increase their engagement in educational and employment opportunities among Medicaid beneficiaries most at risk for poor health outcomes associated with poverty;
- Reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings; and
- Increase the use of preventative care and health screenings

Summary
To achieve the above, the Division of Medical Services amended the Medicaid State Plan to provide women with high-risk pregnancies who are eligible for Medicaid but are not in the New Adult Medicaid Expansion Group the opportunity to receive home-visiting services through the Life360 HOMES program. The amendment allows for hospitals approved to provide Maternal Life360 HOMES services to receive $300 per member per month for women enrolled in the Maternal Life 360 HOMES program through fee for service traditional Medicaid. The SPA conforms to the recently promulgated Life360HOMES provider manual.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

_____ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

B. Areas of State in which services will be provided (§1915(g)(1) of the Act):

__X__ Entire State

___ Only in the following geographic areas:

C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

_____ Services are provided in accordance with §1902(a)(10)(B) of the Act.

__X__ Services are not comparable in amount duration and scope (§1915(g)(1)).

D. Definition of services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management may be delivered through home visits and includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
   - Taking client history;
   - Identifying the individual's needs and completing related documentation; and
   - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
   - Assessments/Reassessments are required at least annually.

MARK-UP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

D. Definitions of Services (continued)

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
   - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
   - Identifies a course of action to respond to the assessed needs of the eligible individual;
   - Care plans must be updated/renewed at least annually.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
   - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

4. Monitoring and follow-up activities:
   - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     - Services are being furnished in accordance with the individual's care plan;
     - Services in the care plan are adequate; and
     - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

MARKUP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

D. Definition of Services (continued)

Case managers will continue to monitor and follow-up on the care plan while conducting case management activities, including assessments, referrals and linkages to service providers, during visits. The visits may be as frequent as needed by the client but must be at least every 30 days, which will allow regular assessment of the plan implementation. The case manager will assess the services or community resources received and adequacy of the services. The case manager also will identify the beneficiaries' action steps, determine whether they require additional support or adjustments of services or activities and document relevant activities/changes. At least annually the care plan must be fully reviewed with beneficiaries to ensure the activities are relevant, appropriate and are being followed and update the plan as necessary. Beneficiary interviews may occur through a home visit, face-to face office visit, or other contact method that allows gathering the information needed.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

MARKUP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Hospital providers licensed as general hospitals with an obstetrics unit with a model recognized by the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HOMEVEE) program to be effective in improving maternal and child health that have applied and been approved to become Maternal Life360 providers. The hospital may use its own staff or subcontract for case management. Case managers employed by the hospital will have no direct relationship with the inpatient department, and case management services will not be provided by the inpatient or acute unit of the hospital. Case managers will be focused on the person-centered care delivered for the beneficiaries in the community and will not duplicate coordination provided through other hospital-delivered services. Case managers delivering this benefit must be able to provide all components of targeted case management within their scope of practice. Case managers must also meet the following criteria:

- A minimum or a high school diploma or GED and experience with early childhood education, childhood development, or social work, family support, maternity, or case management services, or demonstrated comparable experience or competency through educational or other professional activities to provide the required TCM services for the population.

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

MARKUP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

H. Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

MARKUP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

J. Monitoring

Providers must meet established standards that measure services under this program/state plan service to eligible beneficiaries. The State will monitor performance on these standards through monthly expenditure reporting and quarterly progress reporting. Providers will use the MMIS to enroll individuals and enter visits provided in order to monitor individual enrollment and services rendered. The state will also review quality metrics for individual provider- and system-level goals.

The state will ensure that providers meet acceptable performance, including the process and health outcomes and case documentation/program reporting, and will address any identified non-compliance for these services. Audits will ensure case records are maintained as required.

K. Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

MARK-UP

State Plan under Title XIX of the Social Security Act
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High-Risk Pregnant Women

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

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_____ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

B. Areas of State in which services will be provided (§1915(g)(1) of the Act):

__**X**__ Entire State

_____ Only in the following geographic areas:

C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

_____ Services are provided in accordance with §1902(a)(10)(B) of the Act.

__**X**__ Services are not comparable in amount duration and scope (§1915(g)(1)).

D. Definition of services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management may be delivered through home visits and includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
   - Taking client history;
   - Identifying the individual's needs and completing related documentation; and
   - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
   - Assessments/Reassessments are required at least annually.

MARK-UP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

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D. Definitions of Services (continued)

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
   - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
   - Identifies a course of action to respond to the assessed needs of the eligible individual;
   - Care plans must be updated/renewed at least annually.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
   - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

4. Monitoring and follow-up activities:
   - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     - Services are being furnished in accordance with the individual's care plan;
     - Services in the care plan are adequate; and
     - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

MARK-UP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

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D. Definition of Services (continued)

Case managers will continue to monitor and follow-up on the care plan while conducting case management activities, including assessments, referrals and linkages to service providers, during visits. The visits may be as frequent as needed by the client but must be at least every 30 days, which will allow regular assessment of the plan implementation. The case manager will assess the services or community resources received and adequacy of the services. The case manager also will identify the beneficiaries' action steps, determine whether they require additional support or adjustments of services or activities and document relevant activities/changes. At least annually the care plan must be fully reviewed with beneficiaries to ensure the activities are relevant, appropriate and are being followed and update the plan as necessary. Beneficiary interviews may occur through a home visit, face-to face office visit, or other contact method that allows gathering the information needed.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

MARKUP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Hospital providers licensed as general hospitals with an obstetrics unit with a model recognized by the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HOMEVEE) program to be effective in improving maternal and child health that have applied and been approved to become Maternal Life360 providers. The hospital may use its own staff or subcontract for case management. Case managers employed by the hospital will have no direct relationship with the inpatient department, and case management services will not be provided by the inpatient or acute unit of the hospital. Case managers will be focused on the person-centered care delivered for the beneficiaries in the community and will not duplicate coordination provided through other hospital-delivered services. Case managers delivering this benefit must be able to provide all components of targeted case management within their scope of practice. Case managers must also meet the following criteria:

- A minimum or a high school diploma or GED and experience with early childhood education, childhood development, or social work, family support, maternity, or case management services, or demonstrated comparable experience or competency through educational or other professional activities to provide the required TCM services for the population.

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

MARKUP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

H. Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

MARKUP

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

J. Monitoring

Providers must meet established standards that measure services under this program/state plan service to eligible beneficiaries. The State will monitor performance on these standards through monthly expenditure reporting and quarterly progress reporting. Providers will use the MMIS to enroll individuals and enter visits provided in order to monitor individual enrollment and services rendered. The state will also review quality metrics for individual provider- and system-level goals.

The state will ensure that providers meet acceptable performance, including the process and health outcomes and case documentation/program reporting, and will address any identified non-compliance for these services. Audits will ensure case records are maintained as required.

K. Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

MARK-UP

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE Revised: ~~November 1, 1997~~ January 1, 2023

~~Reserved~~

19. Case Management Services

E. High-Risk Pregnant Women

Program Rates

Effective January 1, 2023, targeted case management services provided by a qualified enrolled provider described in Supplement 1-Attachment 3.1-A and Supplement 1 Attachment 3.1-B Targeted Case Management Services, High-Risk Pregnant Women shall be reimbursed a per member per month rate (PMPM), in the amount of $300. At least one of the services described in Supplement 1-Attachment 3.1-A or Supplement 1 Attachment 3.1-B Targeted Case Management Services, High-Risk Pregnant Women included in the PMPM must be provided within the service payment unit in order for providers to bill the PMPM rate.

Any provider delivering services through the PMPM will be paid the PMPM rate and cannot bill separately; and, Medicaid providers delivering separate services outside of the PMPM may bill for those separate services in accordance with the state plan.

Payment for targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Payments shall be limited to a maximum of 12 months postpartum.

Limitations

Case management does not include expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service.

Case management does not include expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

Program Rates Development and Adjustments

Existing state program costs reviewed included the State's 2021 Maternal and Infant Early Childhood Home Visiting (MIECHV) program budget request that included staff salaries, other direct program costs to provide the services, and administration. Room and board, and other unallowable facility costs were not considered in the rate development. The state will review data of all enrolled providers at least annually, ensure beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part per member per month rate.

In Effect

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

B. Areas of State in which services will be provided (§1915(g)(1) of the Act):

__X_ Entire State

___ Only in the following geographic areas:

C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

_X__ Services are not comparable in amount duration and scope (§1915(g)(1)).

D. Definition of services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management may be delivered through home visits and includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
   - Taking client history;
   - Identifying the individual's needs and completing related documentation; and
   - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
   - Assessments/Reassessments are required at least annually.

PROPOSED

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

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D. Definitions of Services (continued)

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
   - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
   - Identifies a course of action to respond to the assessed needs of the eligible individual;
   - Care plans must be updated/renewed at least annually.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
   - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

4. Monitoring and follow-up activities:
   - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     - Services are being furnished in accordance with the individual's care plan;
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D. Definition of Services (continued)

Case managers will continue to monitor and follow-up on the care plan while conducting case management activities, including assessments, referrals and linkages to service providers, during visits. The visits may be as frequent as needed by the client but must be at least every 30 days, which will allow regular assessment of the plan implementation. The case manager will assess the services or community resources received and adequacy of the services. The case manager also will identify the beneficiaries' action steps, determine whether they require additional support or adjustments of services or activities and document relevant activities/changes. At least annually the care plan must be fully reviewed with beneficiaries to ensure the activities are relevant, appropriate and are being followed and update the plan as necessary. Beneficiary interviews may occur through a home visit, face-to face office visit, or other contact method that allows gathering the information needed.

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- A minimum or a high school diploma or GED and experience with early childhood education, childhood development, or social work, family support, maternity, or case management services, or demonstrated comparable experience or competency through educational or other professional activities to provide the required TCM services for the population.

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State/Territory: Arkansas

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High-Risk Pregnant Women

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State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

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B. Areas of State in which services will be provided (§1915(g)(1) of the Act):

__X_ Entire State

___ Only in the following geographic areas:

C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

_X__ Services are not comparable in amount duration and scope (§1915(g)(1)).

D. Definition of services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management may be delivered through home visits and includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
   - Taking client history;
   - Identifying the individual's needs and completing related documentation; and
   - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
   - Assessments/Reassessments are required at least annually.

PROPOSED

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

D. Definitions of Services (continued)

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
   - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
   - Identifies a course of action to respond to the assessed needs of the eligible individual;
   - Care plans must be updated/renewed at least annually.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
   - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

4. Monitoring and follow-up activities:
   - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     - Services are being furnished in accordance with the individual's care plan;
     - Services in the care plan are adequate; and
     - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

PROPOSED

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

D. Definition of Services (continued)

Case managers will continue to monitor and follow-up on the care plan while conducting case management activities, including assessments, referrals and linkages to service providers, during visits. The visits may be as frequent as needed by the client but must be at least every 30 days, which will allow regular assessment of the plan implementation. The case manager will assess the services or community resources received and adequacy of the services. The case manager also will identify the beneficiaries' action steps, determine whether they require additional support or adjustments of services or activities and document relevant activities/changes. At least annually the care plan must be fully reviewed with beneficiaries to ensure the activities are relevant, appropriate and are being followed and update the plan as necessary. Beneficiary interviews may occur through a home visit, face-to face office visit, or other contact method that allows gathering the information needed.

_X__Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

PROPOSED

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Hospital providers licensed as general hospitals with an obstetrics unit with a model recognized by the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HOMEVEE) program to be effective in improving maternal and child health that have applied and been approved to become Maternal Life360 providers. The hospital may use its own staff or subcontract for case management. Case managers employed by the hospital will have no direct relationship with the inpatient department, and case management services will not be provided by the inpatient or acute unit of the hospital. Case managers will be focused on the person-centered care delivered for the beneficiaries in the community and will not duplicate coordination provided through other hospital-delivered services. Case managers delivering this benefit must be able to provide all components of targeted case management within their scope of practice. Case managers must also meet the following criteria:

- A minimum or a high school diploma or GED and experience with early childhood education, childhood development, or social work, family support, maternity, or case management services, or demonstrated comparable experience or competency through educational or other professional activities to provide the required TCM services for the population.

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

PROPOSED

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

H. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

PROPOSED

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

J. Monitoring

Providers must meet established standards that measure services under this program/state plan service to eligible beneficiaries. The State will monitor performance on these standards through monthly expenditure reporting and quarterly progress reporting. Providers will use the MMIS to enroll individuals and enter visits provided in order to monitor individual enrollment and services rendered. The state will also review quality metrics for individual provider- and system-level goals.

The state will ensure that providers meet acceptable performance, including the process and health outcomes and case documentation/program reporting, and will address any identified non-compliance for these services. Audits will ensure case records are maintained as required.

K. Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

PROPOSED

19. Case Management Services

E. High-Risk Pregnant Women

Program Rates

Effective January 1, 2023, targeted case management services provided by a qualified enrolled provider described in Supplement 1-Attachment 3.1-A and Supplement 1 Attachment 3.1-B Targeted Case Management Services, High-Risk Pregnant Women shall be reimbursed a per member per month rate (PMPM), in the amount of $300. At least one of the services described in Supplement 1-Attachment 3.1-A or Supplement 1 Attachment 3.1-B Targeted Case Management Services, High-Risk Pregnant Women included in the PMPM must be provided within the service payment unit in order for providers to bill the PMPM rate.

Any provider delivering services through the PMPM will be paid the PMPM rate and cannot bill separately; and, Medicaid providers delivering separate services outside of the PMPM may bill for those separate services in accordance with the state plan.

Payment for targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Payments shall be limited to a maximum of 12 months postpartum.

Limitations

Case management does not include expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service.

Case management does not include expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

Program Rates Development and Adjustments

Existing state program costs reviewed included the State's 2021 Maternal and Infant Early Childhood Home Visiting (MIECHV) program budget request that included staff salaries, other direct program costs to provide the services, and administration. Room and board, and other unallowable facility costs were not considered in the rate development. The state will review data of all enrolled providers at least annually, ensure beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part per member per month rate.

PROPOSED

State of Arkansas *As Engrossed: S3/8/21*
93rd General Assembly **A Bill**
Regular Session, 2021 SENATE BILL 410

By: Senator Irvin
By: Representative M. Gray

For An Act To Be Entitled

AN ACT TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; TO PROMOTE ECONOMIC AND PERSONAL HEALTH, PERSONAL INDEPENDENCE, AND OPPORTUNITY FOR ARKANSANS THROUGH PROGRAM PLANNING AND INITIATIVES; TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; AND TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM.

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

SECTION 1. Arkansas Code Title 23, Chapter 61, Subchapter 10 is amended to read as follows:

Subchapter 10 — ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021

23-61-1001. Title.

This subchapter shall be known and may be cited as the "~~Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021".

23-61-1002. Legislative intent.

Notwithstanding any general or specific laws to the contrary, it is the intent of the General Assembly for the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program to be a fiscally sustainable, cost-effective, and opportunity-driven program that:

~~(1) Empowers individuals to improve their economic security and achieve self-reliance;~~

~~(2) Builds on private insurance market competition and value-based insurance purchasing models;~~

~~(3) Strengthens the ability of employers to recruit and retain productive employees; and~~

~~(4)~~(1) Achieves comprehensive and innovative healthcare reform that reduces the rate of growth in state and federal obligations for ~~entitlement spending~~ providing healthcare coverage to low-income adults in Arkansas;

(2) Reduces the maternal and infant mortality rates in the state through initiatives that promote healthy outcomes for eligible women with high-risk pregnancies;

(3) Promotes the health, welfare, and stability of mothers and their infants after birth through hospital-based community bridge organizations;

(4) Encourages personal responsibility for individuals to demonstrate that they value healthcare coverage and understand their roles and obligations in maintaining private insurance coverage;

(5) Increases opportunities for full-time work and attainment of economic independence, especially for certain young adults, to reduce long-term poverty that is associated with additional risk for disease and premature death;

(6) Addresses health-related social needs of Arkansans in rural counties through hospital-based community bridge organizations and reduces the additional risk for disease and premature death associated with living in a rural county;

(7) Strengthens the financial stability of the critical access hospitals and other small, rural hospitals; and

(8) Fills gaps in the continuum of care for individuals in need of services for serious mental illness and substance use disorders.

23-61-1003. Definitions.

As used in this subchapter:

~~(1) "Cost-effective" means that the cost of covering employees who are:~~

~~(A) Program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through individual qualified health insurance plans; or~~

~~(B) Eligible individuals who are not program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through a program authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2016;~~

(1) "Acute care hospital" means a hospital that:

(A) Is licensed by the Department of Health under § 20-9-201 et seq., as a general hospital or a surgery and general medical care hospital; and

(B) Is enrolled as a provider with the Arkansas Medicaid Program;

(2) "Birthing hospital" means a hospital in this state or in a border state that:

(A) Is licensed as a general hospital;

(B) Provides obstetrics services; and

(C) Is enrolled as a provider with the Arkansas Medicaid Program;

(3) "Community bridge organization" means an organization that is authorized by the Department of Human Services to participate in the economic independence initiative or the health improvement initiative to:

(A) Screen and refer Arkansans to resources available in their communities to address health-related social needs; and

(B) Assist eligible individuals identified as target populations most at risk of disease and premature death and who need a higher level of intervention to improve their health outcomes and succeed in meeting

their long-term goals to achieve independence, including economic independence;

~~(2)~~(4) "Cost sharing" means the portion of the cost of a covered medical service that is required to be paid by or on behalf of an eligible individual;

(5) "Critical access hospital" means an acute care hospital that is:

(A) Designated by the Centers for Medicare and Medicaid Services as a critical access hospital; and

(B) Is enrolled as a provider in the Arkansas Medicaid Program;

(6) "Economic independence initiative" means an initiative developed by the Department of Human Services that is designed to promote economic stability by encouraging participation of program participants to engage in full-time, full-year work, and to demonstrate the value of enrollment in an individual qualified health insurance plan through incentives and disincentives;

~~(3)~~(7) "Eligible individual" means an individual who is in the eligibility category created by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a;

~~(4)~~(8) "Employer health insurance coverage" means a health insurance benefit plan offered by an employer or, as authorized by this subchapter, an employer self-funded insurance plan governed by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended;

(9) "Health improvement initiative" means an initiative developed by an individual qualified health insurance plan or the Department of Human Services that is designed to encourage the participation of eligible individuals in health assessments and wellness programs, including fitness programs and smoking or tobacco cessation programs;

~~(5)~~(10) "Health insurance benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, but not including excepted benefits as defined under 42 U.S.C. § 300gg-91(c), as it existed on ~~January 1, 2016~~ January 1, 2021;

~~(6)~~(11) "Health insurance marketplace" means the applicable entities that were designed to help individuals, families, and businesses in

Arkansas shop for and select health insurance benefit plans in a way that permits comparison of available plans based upon price, benefits, services, and quality, and refers to either:

(A) The Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or a successor entity; or

(B) The federal health insurance marketplace or federal health benefit exchange created under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148;

~~(7)~~(12) "Health insurer" means an insurer authorized by the State Insurance Department to provide health insurance or a health insurance benefit plan in the State of Arkansas, including without limitation:

(A) An insurance company;

(B) A medical services plan;

(C) A hospital plan;

(D) A hospital medical service corporation;

(E) A health maintenance organization;

(F) A fraternal benefits society; ~~or~~

(G) Any other entity providing health insurance or a health insurance benefit plan subject to state insurance regulation; or

(H) A risk-based provider organization licensed by the Insurance Commissioner under § 20-77-2704;

(13) "Healthcare coverage" means coverage provided under this subchapter through either an individual qualified health insurance plan, a risk-based provider organization, employer health insurance coverage, or the fee-for-service Arkansas Medicaid Program;

~~(8)~~(14) "Individual qualified health insurance plan" means an individual health insurance benefit plan offered by a health insurer ~~through~~ that participates in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations, as they existed on ~~January 1, 2016~~ January 1, 2021;

(15) "Member" means a program participant who is enrolled in an individual qualified health insurance plan;

~~(9)~~(16) "Premium" means a monthly fee that is required to be paid by or on behalf of an eligible individual to maintain some or all health

insurance benefits;

~~(10)~~(17) "Program participant" means an eligible individual who:

(A) Is at least nineteen (19) years of age and no more than sixty-four (64) years of age with an income that meets the income eligibility standards established by rule of the Department of Human Services;

(B) Is authenticated to be a United States citizen or documented qualified alien according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193;

(C) Is not eligible for Medicare or advanced premium tax credits through the health insurance marketplace; and

(D) Is not determined ~~to be more effectively covered through the traditional Arkansas Medicaid Program, including without limitation:~~ by the Department of Human Services to be medically frail or eligible for services through a risk-based provider organization;

~~(i) An individual who is medically frail; or~~

~~(ii) An individual who has exceptional medical needs for whom coverage offered through the health insurance marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care; and~~

~~(11)(A) "Small group plan" means a health insurance benefit plan for a small employer that employed an average of at least two (2) but no more than fifty (50) employees during the preceding calendar year.~~

~~(B) "Small group plan" does not include a grandfathered health insurance plan as defined in 45 C.F.R. § 147.140(a)(1)(i), as it existed on January 1, 2016~~

(18) "Risk-based provider organization" means the same as defined in § 20-77-2703; and

(19) "Small rural hospital" means a critical access hospital or a general hospital that:

(A) Is located in a rural area;

(B) Has fifty (50) or fewer staffed beds; and

(C) Is enrolled as a provider in the Arkansas Medicaid Program.

23-61-1004. Administration ~~of Arkansas Works Program~~.

(a)(1) The Department of Human Services, in coordination with the State Insurance Department and other ~~necessary~~ state agencies, as necessary, shall:

(A) Provide ~~health insurance or medical assistance~~ healthcare coverage under this subchapter to eligible individuals;

(B) Create and administer the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program by:~~;~~

~~(C)~~(i) ~~Submit and apply~~ Applying for any federal waivers, Medicaid state plan amendments, or other authority necessary to implement the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program in a manner consistent with this subchapter; and

(ii) Administering the Arkansas Health and Opportunity for Me Program as approved by the Centers for Medicare and Medicaid Services;

(C)(i) Administer the economic independence initiative designed to reduce the short-term effects of the work penalty and the long-term effects of poverty on health outcomes among program participants through incentives and disincentives.

(ii) The Department of Human Services shall align the economic independence initiative with other state-administered work-related programs to the extent practicable;

(D) Screen, refer, and assist eligible individuals through community bridge organizations under agreements with the Department of Human Services;

~~(D)~~(E) Offer ~~incentive benefits~~ incentives to promote personal responsibility, individual health, and economic independence through individual qualified health insurance plans and community bridge organizations; and

~~(E)~~(F) Seek a waiver to ~~eliminate~~ reduce the period of retroactive eligibility for an eligible individual under this subchapter to thirty (30) days before the date of the application.

(2) The Governor shall request the assistance and involvement of other state agencies that he or she deems necessary for the implementation of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

(b) ~~Health insurance benefits~~ Healthcare coverage under this subchapter shall be provided through enrollment in:

~~(1) Individual premium assistance for enrollment of Arkansas Works Program participants in~~ An individual qualified health insurance ~~plans~~ plan through a health insurer; ~~and~~

~~(2) Supplemental benefits to incentivize personal responsibility~~ A risk-based provider organization;

(3) An employer-sponsored health insurance coverage; or

(4) Fee-for-service Medicaid program.

(c) ~~The~~ Annually, the Department of Human Services~~, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall promulgate and administer rules to implement the Arkansas Works Program.~~ shall develop purchasing guidelines that:

(1) Describe which individual qualified health insurance plans are suitable for purchase in the next demonstration year, including without limitation:

(A) The level of the plan;

(B) The amounts of allowable premiums;

(C) Cost sharing;

(D) Auto-assignment methodology; and

(E) The total per-member-per-month enrollment range; and

(2) Ensure that:

(A) Payments to an individual qualified health insurance plan do not exceed budget neutrality limitations in each demonstration year;

(B) The total payments to all of the individual qualified health insurance plans offered by the health insurers for eligible individuals combined do not exceed budget targets for the Arkansas Health and Opportunity for Me Program in each demonstration year that the Department of Human Services may achieve by:

(i) Setting in advance an enrollment range to represent the minimum and a maximum total monthly number of enrollees into all individual qualified health insurance plans no later than April 30 of each demonstration year in order for the individual qualified health insurance plans to file rates for the following demonstration year;

(ii) Temporarily suspending auto-assignment into the individual qualified health insurance plans at any time in a demonstration year if necessary, to remain within the enrollment range and budget targets for the demonstration year; and

(iii) Developing a methodology for random auto-assignment of program participants into the individual qualified health insurance plans after a suspension period has ended;

(C) Individual qualified health insurance plans meet and report quality and performance measurement targets set by the Department of Human Services; and

(D) At least two (2) health insurers offer individual qualified health insurance plans in each county in the state.

(d)(1) The Department of Human Services, the State Insurance Department, and each of the individual qualified health insurance plans shall enter into a memorandum of understanding that shall specify the duties and obligations of each party in the operation of the Arkansas Health and Opportunity for Me Program, including provisions necessary to effectuate the purchasing guidelines and reporting requirements, at least thirty (30) calendar days before the annual open enrollment period.

(2) If a memorandum of understanding is not fully executed with a health insurer by January 1 of each new demonstration year, the Department of Human Services shall suspend auto-assignment of new members to the health insurers until the first day of the month after the new memorandum of understanding is fully executed.

(3) The memorandum of understanding shall include financial sanctions determined appropriate by the Department of Human Services that may be applied if the Department of Human Services determines that an individual qualified health insurance plan has not met the quality and performance measurement targets or any other condition of the memorandum of *understanding.*

(4)(A) If the Department of Human Services determines that the individual qualified health insurance plans have not met the quality and health performance targets for two (2) years, the Department of Human Services shall develop additional reforms to achieve the quality and health performance targets.

(B) If legislative action is required to implement the additional reforms described in subdivision (d)(4)(A) of this section, the Department of Human Services may take the action to the Legislative Council or the Executive Subcommittee of the Legislative Council for immediate action.

(e) The Department of Human Services shall:

(1) Adopt premiums and cost sharing levels for individuals enrolled in the Arkansas Health and Opportunity for Me Program, not to exceed aggregate limits under 42 C.F.R. § 447.56;

(2)(A) Establish and maintain a process for premium payments, advanced cost-sharing reduction payments, and reconciliation payments to health insurers.

(B) The process described in subdivision (e)(2)(A) of this section shall attribute any unpaid member liabilities as solely the financial obligation of the individual member.

(C) The Department of Human Services shall not include any unpaid individual member obligation in any payment or financial reconciliation with health insurers or in a future premium rate; and

(3)(A) Calculate a total per-member-per-month amount for each individual qualified health insurance plan based on all payments made by the Department of Human Services on behalf of an individual enrolled in the individual qualified health insurance plan.

(B)(i) The amount described in subdivision (e)(3)(A) of this section shall include premium payments, advanced cost-sharing reduction payments for services provided to covered individuals during the demonstration year, and any other payments accruing to the budget neutrality target for plan-enrolled individuals made during the demonstration year and the member months for each demonstration year.

(ii) The total per-member-per-month upper limit is the budget neutrality per-member-per-month limit established in the approved demonstration for each demonstration year.

(C) If the Department of Human Services calculates that the total per-member-per-month for an individual qualified health insurance plan for that demonstration year exceeds the budget neutrality per-member-per-month limit for that demonstration year, the Department of Human Services shall not make any additional reconciliation payments to the health insurer for that individual qualified health insurance plan.

(D) If the Department of Human Services determines that the budget neutrality limit has been exceeded, the Department of Human Services shall recover the excess funds from the health insurer for that individual qualified health insurance plan.

~~(d)(1)~~(f)(1) If the ~~Within thirty (30) days of a reduction in~~ federal medical assistance percentages ~~as described in this section~~ for the Arkansas Health and Opportunity for Me Program are reduced to below ninety percent (90%), the Department of Human Services shall present to the Centers for Medicare and Medicaid Services a plan within thirty (30) days of the reduction to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and transition eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program within one hundred twenty (120) days of ~~a~~ the reduction ~~in any of the following federal medical assistance percentages:~~

~~(A) Ninety-five percent (95%) in the year 2017;~~

~~(B) Ninety-four percent (94%) in the year 2018;~~

~~(C) Ninety-three percent (93%) in the year 2019; and~~

~~(D) Ninety percent (90%) in the year 2020 or any year after the year 2020~~.

(2) An eligible individual shall maintain coverage during the process to implement the plan to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and the transition of eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

~~(e) State obligations for uncompensated care shall be tracked and reported to identify potential incremental future decreases.~~

~~(f) The Department of Human Services shall track the hospital assessment fee imposed by § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.~~

~~(g)(1) On a quarterly basis, the Department of Human Services, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding the overall Arkansas Works Program, including without limitation:~~

~~(A) Eligibility and enrollment;~~

~~(B) Utilization;~~

~~(C) Premium and cost-sharing reduction costs;~~

~~(D) Health insurer participation and competition;~~

~~(E) Avoided uncompensated care; and~~

~~(F) Participation in job training and job search programs.~~

~~(2)(A)~~(g)(1) A health insurer ~~who~~ that is providing an individual qualified health insurance plan or employer health insurance coverage for an eligible individual shall submit claims and enrollment data to the ~~State Insurance Department~~ Department of Human Services to facilitate reporting required under this subchapter or other state or federally required reporting or evaluation activities.

~~(B)~~(2) A health insurer may utilize existing mechanisms with supplemental enrollment information to fulfill requirements under this subchapter, including without limitation the state's all-payer claims database established under the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq., for claims and enrollment data submission.

(h)(1) The Governor shall request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose.

(2) The Governor shall request a waiver under relevant federal law and regulations for a work requirement as a condition of maintaining coverage in the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a waiver for this purpose.

23-61-1005. Requirements for eligible individuals.

~~(a)(1) To promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors, an eligible individual shall receive a wellness visit from a primary care provider within:~~

~~(A) The first year of enrollment in health insurance coverage for an eligible individual who is not a program participant and is enrolled in employer health insurance coverage; and~~

~~(B) The first year of, and thereafter annually:~~

~~(i) Enrollment in an individual qualified health insurance plan or employer health insurance coverage for a program participant; or~~

~~(ii) Notice of eligibility determination for an eligible individual who is not a program participant and is not enrolled in employer health insurance coverage.~~

~~(2) Failure to meet the requirement in subdivision (a)(1) of~~

~~this section shall result in the loss of incentive benefits for a period of up to one (1) year, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(b)(1) An eligible individual who has up to fifty percent (50%) of the federal poverty level at the time of an eligibility determination shall be referred to the Division of Workforce Services to:~~

~~(A) Incentivize and increase work and work training opportunities; and~~

~~(B) Participate in job training and job search programs.~~

~~(2) The Department of Human Services or its designee shall provide work training opportunities, outreach, and education about work and work training opportunities through the Division of Workforce Services to all eligible individuals regardless of income at the time of an eligibility determination.~~

(a) An eligible individual is responsible for all applicable cost-sharing and premium payment requirements as determined by the Department of Human Services.

(b) An eligible individual may participate in a health improvement initiative, as developed and implemented by either the eligible individual's individual qualified health insurance plan or the department.

(c)(1)(A) An eligible individual who is determined by the department to meet the eligibility criteria for a risk-based provider organization due to serious mental illness or substance use disorder shall be enrolled in a risk-based provider organization under criteria established by the department.

(B) An eligible individual who is enrolled in a risk-based provider organization is exempt from the requirements of subsections (a) and (b) of this section.

(2)(A) An eligible individual who is determined by the department to be medically frail shall receive healthcare coverage through fee-for-service Medicaid.

(B) An eligible individual who is enrolled in the fee-for-service Medicaid program is exempt from the requirements of subsection (a) of this section.

~~(c)~~(d) An eligible individual shall receive notice that:

(1) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity

for Me Program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program is subject to cancellation upon appropriate notice; ~~and~~

(3) ~~The Arkansas Works Program is not an entitlement program~~ Enrollment in an individual qualified health insurance plan is not a right; and

(4) If the individual chooses not to participate or fails to meet participation goals in the economic independence initiative, the individual may lose incentives provided through enrollment in an individual qualified health insurance plan or be unenrolled from the individual qualified health insurance plan after notification by the department.

23-61-1006. Requirements for program participants.

~~(a) A program participant who is twenty-one (21) years of age or older shall enroll in employer health insurance coverage if the employer health insurance coverage meets the standards in § 23-61-1008(a).~~

~~(b)(1) A program participant who has income of at least one hundred percent (100%) of the federal poverty level shall pay a premium of no more than two percent (2%) of the income to a health insurer.~~

~~(2) Failure by the program participant to meet the requirement in subdivision (b)(1) of this section may result in:~~

~~(A) The accrual of a debt to the State of Arkansas; and~~

~~(B)(i) The loss of incentive benefits in the event of failure to pay premiums for three (3) consecutive months, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(ii) However, incentive benefits shall be restored if a program participant pays all premiums owed.~~

(a) The economic independence initiative applies to all program participants in accordance with the implementation schedule of the Department of Human Services.

(b) Incentives established by the department for participation in the economic independence initiative and the health improvement initiative may include, without limitation, the waiver of premium payments and cost-sharing requirements as determined by the department for participation in one (1) or

more initiatives.

(c) Failure by a program participant to meet the cost-sharing and premium payment requirement under § 23-61-1005(a) may result in the accrual of a personal debt to the health insurer or provider.

(d)(1)(A) Failure by the program participant to meet the initiative participation requirements of subsection (b) of this section may result in:

(i) Being unenrolled from the individual qualified health insurance plan; or

(ii) The loss of incentives, as defined by the department.

(B) However, an individual who is unenrolled shall not lose Medicaid healthcare coverage based solely on disenrollment from the individual qualified health insurance plan.

(2) The department shall develop and notify program participants of the criteria for restoring eligibility for incentive benefits that were removed as a result of the program participants' failure to meet the initiative participation requirements of subsection (b) of this section.

(3)(A) A program participant who also meets the criteria of a community bridge organization target population may qualify for additional incentives by successfully completing the economic independence initiative provided through a community bridge organization.

(B) If successfully completing the initiative results in an increase in the program participant's income that exceeds the program's financial eligibility limits, a program participant may receive, for a specified period of time, financial assistance to pay:

(i) The individual's share of employer-sponsored health insurance coverage not to exceed a limit determined by the department; or

(ii) A share of the individual's cost sharing obligation, as determined by the department, if the individual enrolls in a health insurance benefit plan offered through the Arkansas Health Insurance Marketplace.

23-61-1007. Insurance standards for individual qualified health insurance plans.

(a) Insurance coverage for a ~~program participant~~ member enrolled in an

individual qualified health insurance plan shall be obtained, at a minimum, through silver-level metallic plans as provided in 42 U.S.C. § 18022(d) and § 18071, as they existed on ~~January 1, 2016~~ January 1, 2021, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(b) ~~The Department of Human Services shall pay premiums and supplemental cost sharing reductions directly to a health insurer for a program participant enrolled in an individual qualified health insurance plan~~ As provided under § 23-61-1004(e)(2), health insurers shall track the applicable premium payments and cost sharing collected from members to ensure that the total amount of an individual's payments for premiums and cost sharing does not exceed the aggregate cap imposed by 42 C.F.R. § 447.56.

(c) ~~All participating health insurers offering individual qualified health insurance plans in the health insurance marketplace~~ All health benefit plans purchased by the Department of Human Services shall:

(1)~~(A) Offer individual qualified health insurance plans conforming~~ Conform to the requirements of this section and applicable insurance rules~~.~~;

~~(B)~~(2) Be certified by the State Insurance Department; ~~The individual qualified health insurance plans shall be approved by the State Insurance Department; and~~

~~(2)~~(3)(A) Maintain a medical-loss ratio of at least eighty percent (80%) for an individual qualified health insurance plan as required under 45 C.F.R. § 158.210(c), as it existed on ~~January 1, 2016~~ January 1, 2021, or rebate the difference to the Department of Human Services for ~~program participants~~ members.

(B) However, the Department of Human Services may approve up to one percent (1%) of revenues as community investments and as benefit expenses in calculating the medical-loss ratio of a plan in accordance with 45 C.F.R. § 158.150;

(4) Develop:

(A) An annual quality assessment and performance improvement strategic plan to be approved by the Department of Human Services that aligns with federal quality improvement initiatives and quality and reporting requirements of the Department of Human Services; and

(B) Targeted initiatives based on requirements established

by the Department of Human Services in consultation with the Department of Health; and

(5) Make reports to the Department of Human Service and the Department of Health regarding quality and performance metrics in a manner and frequency established by a memorandum of understanding.

~~(d) The State of Arkansas shall assure that at least two (2) individual qualified health insurance plans are offered in each county in the state.~~

~~(e)~~(d) A health insurer offering individual qualified health insurance plans for ~~program participants~~ members shall participate in the Arkansas Patient-Centered Medical Home Program, including:

(1) Attributing enrollees in individual qualified health insurance plans, including ~~program participants~~ members, to a primary care physician;

(2) Providing financial support to patient-centered medical homes to meet practice transformation milestones; and

(3) Supplying clinical performance data to patient-centered medical homes, including data to enable patient-centered medical homes to assess the relative cost and quality of healthcare providers to whom patient-centered medical homes refer patients.

(e)(1) Each individual qualified health insurance plan shall provide for a health improvement initiative, subject to the review and approval of the Department of Human Services, to provide incentives to its enrolled members to participate in one (1) or more health improvement programs as defined in § 23-61-1003(9).

(2)(A) The Department of Human Services shall work with health insurers offering individual qualified health insurance plans to ensure the economic independence initiative offered by the health insurer includes a robust outreach and communications effort which targets specific health, education, training, employment, and other opportunities appropriate for its enrolled members.

(B) The outreach and communications effort shall recognize that enrolled members receive information from multiple channels, including without limitation:

(i) Community service organizations;

(ii) Local community outreach partners;

(iii) Email;

(iv) Radio;

(v) Religious organizations;

(vi) Social media;

(vii) Television;

(viii) Text message; and

(ix) Traditional methods such as newspaper or mail.

(f) On or before ~~January 1, 2017~~ January 1, 2022, the State Insurance Department and the Department of Human Services may implement through certification requirements or rule, or both, the applicable provisions of this section.

~~23-61-1008. [Expired.]~~

23-61-1009. Sunset.

This subchapter shall expire on ~~December 31, 2021~~ December 31, 2026.

23-61-1010. Community bridge organizations.

(a) The Department of Human Services shall develop requirements and qualifications for community bridge organizations to provide assistance to one (1) or more of the following target populations

(1) Individuals who become pregnant with a high-risk pregnancy and the child, throughout the pregnancy and up to twenty-four (24) months after birth;

(2) Individuals in rural areas of the state in need of treatment for serious mental illness or substance use disorder;

(3) Individuals who are young adults most at risk of poor health due to long-term poverty and who meet criteria established by the Department of Human Services, including without limitation the following:

(A) An individual between nineteen (19) and twenty-four (24) years of age who has been previously placed under the supervision of the:

(i) Division of Youth Services; or

(ii) Department of Corrections;

(B) An individual between nineteen (19) and twenty-seven (27) years of age who has been previously placed under the supervision of the

Division of Children and Family Services; or

(C) An individual between nineteen (19) and thirty (30) years of age who is a veteran; and

(4) Any other target populations identified by the Department of Human Services.

(b)(1) Each community bridge organization shall be administered by a hospital under conditions established by the Department of Human Services.

(2) A hospital is eligible to serve eligible individuals under subdivision (a)(1) of this section if the hospital:

(A) Is a birthing hospital;

(B) Provides or contracts with a qualified entity for the provision of a federally recognized evidence-based home visitation model to a woman during pregnancy and to the woman and child for a period of up to twenty-four (24) months after birth; and

(C) Meets any additional criteria established by the Department of Human Services.

(3)(A) A hospital is eligible to serve eligible individuals under subdivision (a)(2) of this section if the hospital:

(i) Is a small rural hospital;

(ii) Screens all Arkansans who seek services at the hospital for health-related social needs;

(iii) Refers Arkansans identified as having health-related social needs for social services available in the community;

(iv) Employs *local qualified staff* to assist eligible individuals in need of treatment for serious mental illness or substance use disorder in accessing medical treatment from healthcare professionals and supports to meet health-related social needs;

(v) Enrolls with Arkansas Medicaid Program as an acute crisis unit provider; and

(vi) Meets any additional criteria established by the Department of Human Services.

(B) The hospital may use funding available through the Department of Human Services to improve the hospital's ability to deliver care through coordination with other healthcare professionals and with the local emergency response system that may include training of personnel and improvements in equipment to support the delivery of medical services through

telemedicine.

(4) A hospital is eligible to serve eligible individuals under subdivision (a)(3) of this section if the hospital:

(A) Is an acute care hospital;

(B) Administers or contracts for the administration programs using proven models, as defined by the Department of Human Services, to provide employment, training, education, or other social supports; and

(C) Meets any additional criteria established by the Department of Human Services.

(c) An individual is not required or entitled to enroll in a community bridge organization as a condition of Medicaid eligibility.

(d) A hospital is not:

(1) Required to apply to become a community bridge organization; or

(2) Entitled to be selected as a community bridge organization.

23-61-1011. Health and Economic Outcomes Accountability Oversight Advisory Panel.

(a) There is created the Health and Economic Outcomes Accountability Oversight Advisory Panel.

(b) The advisory panel shall be composed of the following members:

(1) The following members of the General Assembly:

(A) The Chair of the Senate Committee on Public Health, Welfare, and Labor;

(B) The Chair of the House Committee on Public Health, Welfare, and Labor;

(C) The Chair of the Senate Committee on Education;

(D) The Chair of the House Committee on Education;

(E) The Chair of the Senate Committee on Insurance and Commerce;

(F) The Chair of the House Committee on Insurance and Commerce;

(G) An at-large member of the Senate appointed by the President Pro Tempore of the Senate;

(H) An at-large member of the House of Representatives appointed by the Speaker of the House of Representatives;

(I) An at-large member of the Senate appointed by the minority leader of the Senate; and

(J) An at-large member of the House of Representatives appointed by the minority leader of the House of Representatives;

(2) The Secretary of the Department of Human Services;

(3) The Arkansas Surgeon General;

(4) The Insurance Commissioner;

(5) The heads of the following executive branch agencies or their designees;

(A) Department of Health;

(B) Department of Education;

(C) Department of Corrections;

(D) Department of Commerce; and

(E) Department of Finance and Administration;

(6) The Director of the Arkansas Minority Health Commission; and

(7)(A) Three (3) community members who represent health, *business, or education, who reflect the broad racial and geographic diversity in the state, and who have demonstrated a commitment to improving the* health and welfare of Arkansans, appointed as follows;

(i) One (1) member shall be appointed by and serve at the will of the Governor;

(ii) One (1) member shall be appointed by and serve at the will of the President Pro Tempore of the Senate; and

(iii) One (1) member shall be appointed by and serve at the will of the Speaker of the House of Representatives.

(B) Members serving under subdivision (b)(6)(A) of this section may receive mileage reimbursement.

(c)(1) The Secretary of the Department of Human Services and one (1) legislative member shall serve as the co-chairs of the Health and Economic Outcomes Accountability Oversight Advisory Panel and shall convene meetings quarterly of the advisory panel.

(2) The legislative member who serves as the co-chair shall be selected by majority vote of all legislative members serving on the advisory panel.

(d)(1) The advisory panel shall review, make nonbinding recommendations, and provide advice concerning the proposed quality

performance targets presented by the Department of Human Services for each participating individual qualified health insurance plan.

(2) The advisory panel shall deliver all nonbinding recommendations to the Secretary of the Department of Human Services.

(3)(A) The Secretary of the Department of Human Services, in consultation with the State Medicaid Director, shall determine all quality performance targets for each participating individual qualified health insurance plan.

(B) The Secretary may consider the nonbinding recommendations of the advisory panel when determining quality performance targets for each participating individual qualified health insurance plan.

(e) The advisory panel shall review:

(1) The annual quality assessment and performance improvement strategic plan for each participating individual qualified health insurance plan;

(2) Financial performance of the Arkansas Health and Opportunity for Me Program against the budget neutrality targets in each demonstration year;

(3) Quarterly reports prepared by the Department of Human Services, in consultation with the Department of Commerce, on progress towards meeting economic independence outcomes and health improvement outcomes, including without limitation:

(A) Community bridge organization outcomes;

(B) Individual qualified health insurance plan health improvement outcomes;

(C) Economic independence initiative outcomes; and

(D) Any sanctions or penalties assessed on participating Individual qualified health insurance plans;

(4) Quarterly reports prepared by the Department of Human Services on the Arkansas Health and Opportunity for Me Program, including without limitation:

(A) Eligibility and enrollment;

(B) Utilization;

(C) Premium and cost-sharing reduction costs; and

(D) Health insurer participation and competition; and

(5) Any other topics as requested by the Secretary of the

Department of Human Services.

(f)(1) The advisory panel may furnish advice, gather information, make recommendations, and publish reports.

(2) However, the advisory panel shall not administer any portion of the Arkansas Health and Opportunity for Me Program or set policy.

(g) The Department of Human Services shall provide administrative support necessary for the advisory panel to perform its duties.

(h) The Department of Human Services shall produce and submit a quarterly report incorporating the advisory panel's findings to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the public on the progress in health and economic improvement resulting from the Arkansas Health and Opportunity for Me Program, including without limitation:

(1) Eligibility and enrollment;

(2) Participation in and the impact of the economic independence initiative and the health improvement initiative of the eligible individuals, health insurers, and community bridge organizations;

(3) Utilization of medical services;

(4) Premium and cost-sharing reduction costs; and

(5) Health insurer participation and completion.

20-61-1012. Rules.

The Department of Human Services shall adopt rules necessary to implement this subchapter.

SECTION 2. Arkansas Code § 19-5-984(b)(2)(D), concerning the Division of Workforce Services Special Fund, is amended to read as follows:

(D) The ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., or its successor; and

SECTION 3. Arkansas Code § 19-5-1146 is amended to read as follows:

19-5-1146. ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me 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 "~~Arkansas Works Program~~ Arkansas Health and Opportunity for

Me Program Trust Fund".

(b) The fund shall consist of:

(1) Moneys saved and accrued under the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation:

(A) Increases in premium tax collections; and

(B) Other spending reductions resulting from the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.; and

(2) Other revenues and funds authorized by law.

(c) The Department of Human Services shall use the fund to pay for future obligations under the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program created by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.

SECTION 4. Arkansas Code § 23-61-803(h), concerning the creation of the Arkansas Health Insurance Marketplace, is amended to read as follows:

(h) The State Insurance Department and any eligible entity under subdivision ~~(e)(1)~~ (e)(2) of this section shall provide claims and other plan and enrollment data to the Department of Human Services upon request to:

(1) Facilitate compliance with reporting requirements under state and federal law; and

(2) Assess the performance of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program established by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation the program's quality, cost, and consumer access.

SECTION 5. Arkansas Code § 23-79-1601(2)(A), concerning the definition of "health benefit plan" regarding coverage provided through telemedicine, is amended to read as follows:

(2)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 6. Arkansas Code § 23-79-1801(1)(A), concerning the definition of "health benefit plan" regarding coverage for newborn screening for spinal muscular atrophy, is amended to read as follows:

(1)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 7. Arkansas Code § 26-57-604(a)(1)(B)(ii), concerning the remittance of the insurance premium tax, is amended to read as follows:

(ii) However, the credit shall not be applied as an offset against the premium tax on collections resulting from an eligible individual insured under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003.

SECTION 8. Arkansas Code § 26-57-610(b)(2), concerning the disposition of the insurance premium tax, is amended to read as follows:

(2) The taxes based on premiums collected under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003 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 to the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund and used as required by the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund;

SECTION 9. EFFECTIVE DATE.

This act is effective on and after January 1, 2022.

/s/Irvin

APPROVED: 4/1/21