EMERGENCY RULE 117

PROVIDER-LED ORGANIZATION LICENSURE STANDARDS

MARKUP FROM EMERGENCY RULE

Section 1. Authority

This rule is issued pursuant to Ark. Code Ann. § 23-61-117(b) which authorizes the Arkansas Insurance Commissioner ("Commissioner") to issue rules to regulate the licensure and financial solvency of risk-based provider organizations under Act 775 of 2017 of the 91st Arkansas General Assembly also known as the "Medicaid Provider-Led Organized Care Act" (hereafter, the "Organized Care Act"). In addition, Section Seven (7) of the Organized Care Act requires the Commissioner to adopt rules on or before June 1, 2017 to implement various provisions of the Act.

~~Section 2. Statement of Emergency~~

~~Pursuant to Ark. Code Ann. § 25-15-204(b), the Commissioner finds that imminent peril to the public health, safety, or welfare requires adoption of a rule upon less than thirty (30) days' notice and herein states in writing its reasons for that finding. The Commissioner finds that there is not adequate time to promulgate this proposed Rule under standard rulemaking timelines to comply with the Act's required date of June 1, 2017 for the adoption of a rule to implement the Act. The Organized Care Act was enacted with an emergency clause effective March 31, 2017. The Act requires the Commissioner to adopt a rule to implement the Act on or before June 1, 2017 and to issue conditional licenses on and after July 1, 2017. The Commissioner desires to provide immediate temporary licensure and application requirements in this Emergency Rule to process and review applications by risk-based provider organization interested in participating in the Organized Care Act program under the timelines of that program. The Commissioner, however, intends to adopt a permanent rule on this matter within one-hundred and twenty (120) days from the effective date of this Emergency Rule which will provide a public comment period and administrative hearing.~~

Section 2~~3~~. Purpose

The purpose of this ~~Emergency~~ Rule is to establish licensure and solvency requirements of risk-based provider organizations ("RBPOs") participating in the Organized Care Act. This ~~Emergency~~ Rule provides application requirements of the RBPO participating in the program, addresses standards for imposition of additional amounts of funds above reserve requirements to adjust to risk in Ark. Code Ann. § 20-77-2706 (f)(4)(B), establishes financial reporting requirements of the RBPO, imposes a reasonable fee for the regulation and licensing of the RBPO by rule under § 23-61-117(b)(2), and, finally, prescribes the reporting, forms, and requirements related to the payment of the quarterly tax under Ark. Code Ann. 23-61-117(b)(3).

Section 3~~4~~. Applicability and Scope

A. Certificate of Authority Limited To Participation in the Organized Care Act Program.

This ~~Emergency~~ Rule applies to the licensure and solvency standards of RBPOs, as defined in Ark. Code Ann. § 20-77-2703(13) under the Organized Care Act. Nothing in this Rule is intended to sanction, permit or establish a process for a

provider sponsored organization to obtain a certificate of authority to engage in risk assumption or risk sharing activities in this State, outside of its participation in the Organized Care Act program.

Section 45. Definitions

As used in this Rule:

(1) "ADHS" means the Arkansas Department of Human Services;

(2) "Associated participant" means an organization or individual that is a member or contractor of a risk-based provider organization and provides necessary administrative functions, including without limitation claims processing, data collection, and outcome reporting;

(3) "Capitated" means an actuarially sound healthcare payment that is based on a payment per person that covers the total risk for providing healthcare services as provided in this subchapter for a person;

(4)(A) "Care coordination" means the coordination of healthcare services delivered by healthcare provider teams to empower patients in their health care and to improve the efficiency and effectiveness of the healthcare sector.

(B) "Care coordination" includes without limitation:

(i) Health education and coaching;

(ii) Promoting linkages with medical home services and the healthcare system in general;

(iii) Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;

(iv) Assistance with social determinants of health, such as access to healthy food and exercise; and

(v) Promotion of activities focused on the health of a patient and the community, including without limitation outreach, quality improvement, and patient panel management;

(B)(vi) Community-based management of medication therapy;

(5) "Carrier" means an organization that is licensed or otherwise authorized to provide health insurance or health benefit plans under § 23-85-101 or § 23-76-101;

(A) licensed or otherwise authorized to transact health insurance as an insurance company under § 23-62-103;

(B) authorized to provide healthcare plans under §23-76-108 as a health maintenance organization; or

(C) authorized to issue hospital service or medical service plans as a hospital medical service corporation under §23-75-108.

(6) "Commissioner" means the Arkansas Insurance Commissioner;

(7) "Covered Medicaid beneficiary population" means a group of individuals with:

(A) Significant behavioral health needs, including substance abuse treatment and services, and who are eligible for participation in the Medicaid provider-led organized care system as determined by an independent assessment under criteria established by the Department of Human Services; or

(B) Intellectual or developmental disabilities who are eligible for participation in the Medicaid provider-led organized care system as determined by an independent assessment under criteria established by ADHS;

(C) "Covered Medicaid Beneficiary population" does not include individuals enrolled in any long-term services and supports program under 42 U.S.C. § 1396n or 42 U.S.C. § 1315 by reason of a physical functional limitation;

(8) "Department" means the Arkansas Insurance Department;

(9) "Direct service provider" means an organization or individual that delivers healthcare services to enrollable Medicaid beneficiary populations;

(10) "Enrollable Medicaid beneficiary population" means a group of individuals who are either:

(A) Members of a covered Medicaid beneficiary population; or

(B) Members of a voluntary Medicaid beneficiary population.

(11) "Flexible services" means alternative services that are not included in the state plan or waiver of the Arkansas Medicaid Program and that are appropriate and cost-effective services that improve the health or social determinants of a

member of an enrollable Medicaid beneficiary population that affect the health of the member of an enrollable Medicaid beneficiary population;

(12) "Global payment" means a population-based payment methodology that is actuarially sound and based on an all-inclusive per-person-per-month calculation for all benefits, administration, care management, and care coordination for enrollable Medicaid beneficiary populations;

(13) "Medicaid" means the programs authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq., as they existed on January 1, 2017, for the provision of healthcare services to members of enrollable Medicaid beneficiary populations;

(14) "NAIC" means the National Association of Insurance Commissioners;

(15) "Participating provider" means an organization or individual that is a member or has an ownership interest in of a risk-based provider organization and delivers healthcare services to enrollableMedicaid beneficiary populations;

(16) "Quality incentive pool" means a funding source established and maintained by ADHS to be used to reward risk-based provider organizations that meet or exceed specific performance and outcome measures;

(17) "Risk assumption" or "risk sharing" means, for the purpose of this regulation, a transaction whereby the chance of loss, including the expenses for the delivery of service, with respect to the health care of a person, is transferred to or shared with another entity, in return for a consideration. Examples include but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity agreements;

(18) "Risk based capital" means the "RBC level" defined under Ark. Code Ann. § 23-63-1501 (8); and

(19) "Risk-based provider organization" means an entity that:

(A)(i) Is licensed by the Insurance Commissioner under this Rule.

(ii) Notwithstanding any other provision of law, a risk-based provider organization is an insurance company upon licensure by the Commissioner.

(iii) The Commissioner shall not license a risk-based provider organization except as provided under Subchapter 27 — Medicaid Provider-Led Organized Care Act;

(B) Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and

(C) Is paid by ADHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives services during the period covered by the payment;

(20) "Voluntary Medicaid beneficiary populations" means individuals who are in need of behavioral health services or developmental disabilities services, not otherwise excluded in this subchapter, who are eligible for Medicaid and may elect to enroll in a risk-based provider organization.

Section 56. Certificate of Authority

A. Requirement To Be Newly Formed And Organized.

Unless currently authorized or licensed by the Department as a carrier as defined in Ark. Code Ann. § 20-77-2703(4), no RBPO shall transact business in this State under the Organized Care Act Program unless authorized by a subsisting certificate of authority issued to it by the Commissioner. Unless currently authorized or licensed by the Department as a carrier as defined in Ark. Code Ann. § 20-77-203(4), no RBPO shall be granted a certificate of authority unless it is newly formed and organized for the purpose of its participation in the Organized Care Act Program.

B. Entity Type

The business organization form of an RBPO may be any organization type which permits a valid certificate of authority to be issued to it by the Arkansas Secretary of State. The RBPO must obtain and maintain a valid certificate of authority issued by the Secretary of State.

Section 67. Certificate of Authority Application

A. Requirements

An RBPO may apply for a certificate of authority on a form prescribed by the Commissioner. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant. If no form application is available by the Arkansas Insurance Department until the promulgation of a Final

Rule, an RBPO may apply for a certificate of authority in writing to the Commissioner, and, in the request for a certificate of authority, provide the following information:

(1) The name of the risk-bearing entity (RBPO), the contact information of the RBPO, including business address and phone number of the RBPO. Provide the name, address and contact information for the principal contact person of the RBPO for the Arkansas Insurance Department;

(2) A list of the names, addresses and official positions of the person who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of the directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association.

(3) Pay a non-refundable filing fee of two thousand dollars ($2,000.00) to the Department;

(4) A detailed summary of its proposed business plan with respect to its proposed plan as an RBPO. This business plan shall include, but not be limited to:

a. A description of the services to be provided and the manner in which the RBPO shall provide a network of direct service providers sufficient to ensure that all services to recipients are adequately accessible within time and distance requirements defined by Medicaid;

b. A description or plan of the RBPO to ensure that the requirements are met in Ark. Code Ann. § 20-77-2706(f)(2)(A) through (D) and that the RBPO shall timely process claims under Ark. Code Ann. § 20-77-2706(f)(3);

c. A description of the projected population or numbers of enrollees or beneficiaries to be serviced on an annual basis by the RBPO;

d. Describe the network's form of ownership, including the name and the percentage of ownership interest of all members;

e. A description of the RBPO's capital structure;

f. A quantitative measurement of its capacity to provide contracted services;

g. A detailed description of the procedures to be established to provide due process protections for the enrolled Medicaid beneficiary populations (i.e., reconsiderations, grievance procedures, peer review, case utilization procedures, etc.);

h. A description of the network's geographical service area;

i. An explanation of the techniques to be implemented to ensure continuity of care or benefits for all enrolled Medicaid beneficiaries should the RBPO incur a change in its providers, geographical area or become financially impaired or insolvent. Explain or describe the extent to which enrolled Medicaid beneficiaries are assured continuity of care by Medicaid in the event of change of its providers, geographical area, or due to the circumstance that the RBPO becomes financially impaired to provide contracted services, substantially equivalent to the requirements in Ark. Code Ann. § 23-76-118.

j. An explanation of the plan by the RBPO to assure or protect payment to contracted or participating providers of the RBPO, including subcontracted providers in the plan, for services provided should the RBPO become financially insolvent. Such measures and protections may include access to additional capital, stop-loss insurance, business interruption insurance, etc.

k. A current audit report, if available, certified by an independent certified public accountant, of the applicant's financial condition, or current financial information on a SAP basis, attested to by an officer of the RBPO applicant. In addition, three (3) years of financial projections, including balance sheets, income statements and statements of cash flow must be provided. The financial projections shall contain projected per member per month enrollment at its fiscal year end, and a concise summary of all assumptions used to generate the projections and supported by a statement of an actuarial opinion.

l. A copy of the RBPO's proposed health coverage plan(s), contracts, arrangements, marketing and advertising material.

m. A list of the providers comprising the RBPO's provider network, including each provider's medical designation, field of practice or specialty, licensure or certification category, and a description of the RBPO's procedures for determining, on an on-going basis, that each provider is duly licensed or certified.

n. A list of all entities on whose behalf the RBPO has agreements or contracts to provide health care services under the Organized Care Act Program, including a list of all subcontractors of the RBPO.

o. The parent company's current audited financial statements if the applicant is owned by a parent company.

p. A statement or description identifying sources of additional capital resources that would be available in the event the applicant needs additional capital funding.

(5) Provide biographical backgrounds of all proposed officers, directors, owners and organizers, and information providing confirmation of their background and experience in the management or delivery of the services to be delivered through the RBPO. Such biographical information shall be submitted on the NAIC form, Biographical Affidavit (available upon request). Any person who has managerial involvement or control of a company that underwent any adverse state or federal administrative action shall include information about the adverse administrative action.

(6) Provide a copy of the RBPO's organizational documents (e.g. articles of incorporation, by-laws, partnership agreements, etc.) including any sample contract forms, or generic template contract forms between the RBPO and its participating providers.

(7) Provide a written description evidencing the RBPO ownership or management satisfies the characteristics of an RBPO under Ark. Code Ann. § 20-77-2706 which include:

a. The RBPO holds a valid certificate of authority or instrument of formation issued by the Secretary of State;

b. The RBPO has an ownership interest of not less than fifty-one percent (51%) by participating providers;

c. The RBPO includes within its membership:

(1) One or more of the following Arkansas licensed or certified direct service provider of developmental disabilities services;

(i) Developmental Day Treatment Clinic Services ("DDTCS")

(ii) Private (not state owned and operated) Intermediate Care Facilities for Individuals with Intellectual or Developmental Disabilities (ICF/IDD)

(iii) DDS Waiver Services

(iv) Early Intervention Services ("EI")

(v) Child Health Management Services ("CHMS")

(2) One or more of the following Arkansas licensed or certified direct service provider of behavioral health services:

i) Rehabilitation Services for Persons with Mental Illness ("RSPMI") until June 30, 2018

ii) Outpatient Behavioral Health Agency ("OBHA")

iii) Licensed Mental Health Practitioner ("LMHP") until June 30, 2018

iv.) Independently Licensed Practitioner ("ILP")

(3) An Arkansas licensed hospital or hospital services organization.

(4) An Arkansas licensed physician practice;

(5) A pharmacist who is licensed by the Arkansas State Board of Pharmacy

d. The RBPO has a surety bond in the amount as required under Section Seven (7) of the Organized Care Act.

(8) Provide a copy of any management or administrative contract(s) entered into, or to be entered into, by the RBPO.

(9) Confirm that the RBPO uses standardized codes, billing processes and formats.

(10) Describe how the applicant has the capability to satisfactorily manage the health care coverage issued. This confirmation is to include a detailed description of the RBPO's procedures established and implemented to ensure the maintenance of all books and records necessary to meet all reporting requirements. This requirement can be met through a third party management or administration agreement.

(11) Describe the RBPOs global payment amount awarded, or, if not available, the estimated or projected global payment amount or rates. Describe the actual or projected monthly payments or monthly reimbursement amounts under the global payment to the RBPO by Medicaid. Provide a copy of all contracts between the RBPO and Medicaid related to the RBPOs participation in the Organized Care Act program.

(12) Describe the RBPOs rates or charges to participating providers. This information shall include the basis for the calculation of the rate or charge (e.g., use of usual, customary, and reasonable (UCR) rates).

(13) Describe any and all stop-loss arrangements or reinsurance arrangements of the RBPO for participation in this program.

(14) A copy of the basic organizational document of the RBPO, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents, and all amendments thereto; a copy of the bylaws, rules and regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant.

(15) A copy of any contract made or to be made between any providers and the applicant or persons under Section Seven (7)(A)(4)(M) of this Rule.

(16) Any other information deemed necessary by the commissioner in evaluating the application.

B. Material Changes.

Prior to implementing any material changes in its operations or in the coverage offered by the RBPO, the RBPO must submit to the Commissioner a written description of any material modification to its plan of operation, or a written explanation of any material changes to the information submitted in accordance with this Section. If the Commissioner does not disapprove within sixty (60) days of filing, the modification shall be deemed approved.

Section 7~~8~~. Solvency Standards

All RBPOs shall be responsible for meeting the following solvency standards under this Section at the time of initial licensure, in the evaluation of their application, and continuously thereafter. All RBPOs acting as a carrier under Ark. Code Ann. § 20-77-2703(4) shall be subject to this Section in addition to any other provision in the Arkansas Insurance Code or Rules applicable to its type of organization, unless excluded by this ~~Emergency~~ Rule or the Organized Care Act or by Medicaid pre-emption.

A. Solvency Standards

All RBPOs participating in the Organized Care Act program shall:

(1) meet the reserve or capital requirements under Ark. Code Ann. § 20-77-2706(f)(4) and any additional amounts needed to satisfy Risk-Based Capital Requirements under Ark. Code Ann. § 23-63-1501 et seq. (hereafter, "HMO-RBC"). The reserve requirements in Ark. Code Ann. § 20-77-2706(f)(4) shall refer to the organization's capital or capital and surplus under Statutory Accounting Principles (SAP). The Commissioner may adjust the reserve requirements of the RBPO from initial licensure, on a prospective basis, related to the timing of the RBPO assumption levels of partial to full risk in its business operations. In addition, the Commissioner may consider the extent to which the RBPO has reinsurance or stop loss coverage, or agreements with a licensed insurer or HMO, to cede risk, as a circumstance to reduce or modify reserve or capital requirements under this Section. The Commissioner shall review and approve all such risk sharing agreements including any major modifications thereof.

(2) comply with SAP reporting and file quarterly and annual financial statements with the Department under SAP in the same manner as is required of a health maintenance organization regulated by the Department under Ark. Code Ann. § 23-76-113;

(3) comply with HMO-RBC requirements and reporting;

(4) comply with Ark. Code Ann. § 23-63-601 et seq., referring to assets and liabilities;

(5) comply with Ark. Code Ann. § 23-68-101 et seq., referring to rehabilitation and liquidation;

(6) comply with Ark. Code Ann. § 23-69-134, referring to home office and records and the penalty for unlawful removal of records;

(7) comply with Ark. Code Ann. § 23-76-122 related to examinations, in the same manner as a health maintenance organization;

(8) comply with Sections Ark. Code Ann. §§ 23-60-101 through 23-60-108 and 23-60-110 referring to the scope of the Arkansas Insurance Code;

(9) comply with Sections Ark. Code Ann. §§ 23-61-101, 23-61-201, 23-61-301 referring to the Insurance Commissioner;

(10) comply with Section Ark. Code Ann. §§ 23-63-102 through 23-63-104, 23-63-201, et seq., general provisions, and 23-63-301 et seq., referring to service of process, a registered agent as process agent, serving legal process, and time to plead;

(11) comply with the annual independent audit under Ark. Code Ann. § 23-63-216(a)(5) and actuarial requirements under Ark. Code Ann. § 23-63-216(e)(1) and (e)(2);

(12) comply with the custody of assets requirements under Ark. Code Ann. § 23-69-134; and

(13) comply with the transfer of ownership requirements or acquisition provisions under Ark. Code Ann. § 23-69-142.

Section 89. Market Conduct Related Activities and Network Adequacy

A. RBPO Provider Market Conduct Activities

The Insurance Commissioner is primarily authorized to regulate the financial solvency and licensing of the RBPO under the Organized Care Act. The Insurance Commissioner shall not administratively adjudicate, review, process complaints, enforce or apply provisions of the Arkansas Insurance Code, Rules, Bulletins or Directives upon an RBPO, or contracted third party administrator, if applicable, related to claims payment disputes, claims payment delays, provider payment rate(s), provider credentialing, provider reimbursement programs, network related procedures or filing requirements, if such arise during the course of Organized Care Act Program, unless the complaint or concern relates to "Any Willing Provider" access (Ark. Code Ann. §§ 23-99-201, et seq., 23-99-801 et seq.), or significantly reflects upon the financial condition of the RBPO. Complaints or inquiries about claims payment delays or requirements shall be referred to ADHS.

RBPO Network Adequacy Requirements

ADHS shall be responsible for certifying, approving and monitoring whether an RBPO meets the required network access or network adequacy for services under the Organized Care Act. The Commissioner however shall review network adequacy of the RBPO at licensure, or upon renewal of licensure, but shall accept certification from ADHS that the RBPO has sufficient network adequacy as required under the Organized Care Act.

Section 910. Confidentiality & Workpapers

The confidentiality provisions in the Arkansas Insurance Code and Rules, including but not limited to Ark. Code Ann. § 23-61-103(d)(5), related to actuarial reports, Ark. Code Ann. § 23-61-103(d), related to active investigations or examinations, Ark. Code Ann. § 23-61-107, related to financial records and Ark. Code Ann. § 23-61-207, related to ancillary information and workpapers, shall apply in the same manner to an RBPO as are applied to a health insurer or health maintenance organization.

Section 10~~1~~. Payment of Premium Taxes

Pursuant to Ark. Code Ann. § 26-57-603, a RBPO that is licensed under the Organized Care Act and participates in the Medicaid provider-led organized care system offered by the Arkansas Medicaid Program for enrollable Medicaid beneficiary populations as defined in § 20-77-2703 shall pay to the Treasurer of State through the Commissioner a tax imposed for the privilege of transacting business in this state.

(2) The tax shall be computed at a rate of two and one-half percent (2½%) on the total amount of funds received in global payments to a risk-based provider organization participating in the Medicaid provider-led organized care system.

(3) The tax shall be:

(A) Reported at such times and in such form and context as prescribed by the commissioner; and

(B) Paid on a quarterly basis as prescribed by the Commissioner.

Section 11~~0~~. Effective Date

~~This Emergency Rule shall be effective on the date in which it is signed by the Commissioner and approved for issuance as an Emergency Rule by the Executive Subcommittee of the Arkansas Legislative Council.~~ This Rule shall be effective on and after September 25~~18~~, 2017.

ALLEN W. KERR

INSURANCE COMMISSIONER

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DATE

State of Arkansas *As Engrossed: H3/2/17 H3/10/17 S3/20/17*
91st General Assembly
A Bill
Regular Session, 2017 HOUSE BILL 1706

By: Representatives Pilkington, Davis, Collins, Brown, G. Hodges
By: Senator J. Cooper

For An Act To Be Entitled

AN ACT TO CREATE THE MEDICAID PROVIDER-LED ORGANIZED CARE ACT; TO REFORM THE ARKANSAS MEDICAID PROGRAM TO *IMPROVE PATIENT OUTCOMES; TO DESIGNATE THAT A RISK-BASED PROVIDER ORGANIZATION IS AN INSURANCE COMPANY FOR CERTAIN PURPOSES UNDER ARKANSAS LAW; TO ELIMINATE THE WAITING LIST FOR THE ALTERNATIVE COMMUNITY SERVICES WAIVER PROGRAM; TO DECLARE AN EMERGENCY; AND* FOR OTHER PURPOSES.

Subtitle

TO CREATE THE MEDICAID PROVIDER-LED ORGANIZED CARE ACT; TO DESIGNATE THAT A RISK-BASED PROVIDER ORGANIZATION IS AN INSURANCE COMPANY FOR CERTAIN PURPOSES UNDER ARKANSAS LAW; AND TO DECLARE AN EMERGENCY.

WHEREAS, it is beneficial to the State of Arkansas to be a good steward of public money for sustainable programs for the future; and

WHEREAS, it is beneficial to the people of the State of Arkansas to recognize the inherent value and contribution of individuals with disabilities; and

WHEREAS, it is the policy of the State of Arkansas to:

(1) Respect the rights and privileges conveyed by federal and

state law to beneficiaries who are individuals with disabilities;

(2) Support the right of individuals with disabilities to receive quality services without discrimination; and

(3) Allow an individual with disabilities to:

(A) Participate in all decisions regarding his or her care, including the right to refuse treatment, the right to continuity of care, and the right to choose among providers who participate in his or her network; and

(B) Receive services in his or her local community, or the community of his or her choice, and in the least restrictive setting; and

WHEREAS, the State of Arkansas wishes to affirm the commitment to the principles of full and equal treatment and unlimited opportunities for all Arkansans that are afforded, as of February 1, 2017, to individuals with disabilities as a basic tenet of this legislation,

NOW THEREFORE,

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

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

Subchapter 27 — Medicaid Provider-Led Organized Care Act

20-77-2701. Title.

This subchapter shall be known and may be cited as the "Medicaid Provider-Led Organized Care Act".

20-77-2702. Legislative intent and purpose.

(a) As the single state agency for administration of the medical assistance programs established under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq., the Department of Human Services is authorized by federal law to utilize one (1) or more organizations for providing healthcare services to Medicaid beneficiary populations.

(b) The purpose of this subchapter is to establish a Medicaid provider-led organized care system that administers and delivers healthcare

services for a member of *an enrollable* Medicaid beneficiary population in return for payment.

(c) It is the intent of the General Assembly that the Medicaid provider-led organized care system created by the department shall:

(1) Improve the experience of health care, including without limitation quality of care, access to care, and reliability of care, for *enrollable* Medicaid beneficiary populations;

(2) Enhance the performance of the broader healthcare system leading to improved overall population health;

(3) Slow or reverse spending growth for *enrollable* Medicaid beneficiary populations and for covered services while maintaining quality of care and access to care;

(4) Further the objectives of Arkansas payment reforms and the state's ongoing commitment to innovation;

(5) Discourage excessive use of services;

(6) Reduce waste, fraud, and abuse;

(7) Encourage the most efficient use of taxpayer funds; and

(8) Operate under federal guidelines for patient rights.

20-77-2703. Definitions.

As used in this subchapter:

(1) "Associated participant" means an organization or individual that is a member or contractor of a risk-based provider organization and provides necessary administrative functions, including without limitation claims processing, data collection, and outcome reporting;

(2) "Capitated" means an actuarially sound healthcare payment that is based on a payment per person that covers the total risk for providing healthcare services as provided in this subchapter for a person;

(3)(A) "Care coordination" means the coordination of healthcare services delivered by healthcare provider teams to empower patients in their health care and to improve the efficiency and effectiveness of the healthcare sector.

(B) "Care coordination" includes without limitation:

(i) Health education and coaching;

(ii) *Promotion of links with* medical home services and the healthcare system in general;

(iii) Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;

(iv) Assistance with social determinants of health, *such as access to healthy food and exercise; and*

(v) Promotion of activities focused on the health of a patient and the community, including without limitation outreach, quality improvement, and patient panel management; and

(vii) Community-based management of medication therapy;

(4) "Carrier" means an organization that is:

(A) Licensed or otherwise authorized to transact health insurance as an insurance company under § 23-62-103;

(B) Authorized to provide healthcare plans under § 23-76-108 as a health maintenance organization; or

(C) Authorized to issue hospital service or medical service plans as a hospital medical service corporation under § 23-75-108;

(5)(A) "Covered Medicaid beneficiary population" means a group of individuals with:

(i) Significant behavioral health needs, including substance abuse treatment and services, and who are eligible for participation in the Medicaid provider-led organized care system as determined by an independent assessment under criteria established by the Department of Human Services; or

(ii) Intellectual or developmental disabilities and who are eligible for participation in the Medicaid provider-led organized care system as determined by an independent assessment under criteria established by the department.

(B) "Covered Medicaid beneficiary population" does not include individuals enrolled in a long-term care services and supports program under 42 U.S.C. § 1396n or 42 U.S.C. § 1315, due to a physical functional limitation;

(6) "Direct service provider" means an organization or individual that delivers healthcare services to *enrollable* Medicaid beneficiary *population;*

(7) "Enrollable Medicaid beneficiary population" means a group of individuals who are either:

(A) Members of a covered Medicaid beneficiary population; or

(B) Members of a voluntary Medicaid beneficiary population;

(8) "Flexible services" means alternative services that are not included in the state plan or waiver of the Arkansas Medicaid Program and that are appropriate and cost-effective services that improve the health or social determinants of a member of *an enrollable* Medicaid beneficiary population that affect the health of the member of *an enrollable* Medicaid beneficiary population;

(9) "Global payment" means a population-based payment methodology that *is actuarially sound and based* on an all-inclusive per-person-per-month calculation for all benefits, administration, care management, and care coordination for *enrollable* Medicaid beneficiary populations;

(10) "Medicaid" means the programs authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq., as they existed on January 1, 2017, for the provision of healthcare services to members of *enrollable* Medicaid beneficiary populations;

(11) "Participating provider" means an organization or individual that is *a member of or has an ownership interest in* a risk-based provider organization and delivers healthcare services to *enrollable* Medicaid beneficiary populations;

(12) "Quality incentive pool" means a funding source established and maintained by the department to be used to reward risk-based provider organizations that meet or exceed specific performance and outcome measures;

(13) "Risk-based provider organization" means an entity that:

(A)(i) Is licensed by the Insurance Commissioner under the rules established for risk-based provider organizations by the commissioner.

(ii) Notwithstanding any other provision of law, a risk-based provider organization is an insurance company upon licensure by *the commissioner, but is not deemed an insurer for purposes of the Arkansas Life and Health Insurance Guaranty Association Act, § 23-96-101 et seq.*

(iii) The commissioner shall not license a risk-based provider organization except as provided in this subchapter;

(B) Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to *an enrollable* Medicaid beneficiary population; and

(C) Is paid by the department on a capitated basis with a global payment made, whether or not a particular member of *an enrollable* Medicaid beneficiary population receives services during the period covered by the *payment; and*

(14) "Voluntary Medicaid beneficiary population" means a group of individuals who:

(A) Are in need of behavioral health services or developmental disabilities services;

(B) Are eligible for the Arkansas Medicaid Program; and

(C) May elect to enroll in a risk-based provider organization if the group is not otherwise excluded by this subchapter.

20-77-2704. Licensure by Insurance Commissioner.

(a) The Insurance Commissioner may license for participation in the Medicaid provider-led organized care system one (1) or more risk-based provider organizations that satisfactorily meet licensure requirements and are capable of coordinating the delivery and payment of healthcare services for the *enrollable* Medicaid beneficiary populations.

(b) The commissioner shall require a risk-based provider organization to enroll members of covered Medicaid beneficiary populations statewide.

20-77-2705. Excluded services.

(a) Except as provided in subsection (b) of this section, all healthcare services delivered through the Medicaid provider-led organized care system shall:

(1) Be available for all members of covered Medicaid beneficiary populations; and

(2) *Be comparable* in amount, duration, or scope as compared to other Medicaid-eligible individuals as specified in the state plan for medical assistance.

(b) The Medicaid provider-led organized care system shall be implemented to the extent possible, but shall not include the following services when provided to *enrollable* Medicaid beneficiary populations:

(1) Nonemergency medical transportation in a capitated program;

(2) Dental benefits in a capitated program;

(3) School-based services provided by school employees;

(4) Skilled nursing facility services;

(5) Assisted living facility services;

(6) Human development center services; or

(7) Waiver services provided to adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program.

20-77-2706. Characteristics and duties of risk-based provider organization.

(a) A risk-based provider organization shall:

(1) Be authorized to conduct business in the state;

(2) Hold a valid certificate of authority issued by the Secretary of State;

(3) Have ownership interest of not less than fifty-one percent (51%) by participating providers; and

(4) Include within membership of the risk-based provider *organization:*

(A) An Arkansas licensed or certified direct service provider of developmental disabilities services;

(B) An Arkansas licensed or certified direct service provider of behavioral health services;

(C) An Arkansas licensed hospital or hospital services organization;

(D) An Arkansas licensed physician practice; and

(E) A pharmacist who is licensed by the Arkansas State Board of Pharmacy.

(b) A risk-based provider organization that meets the requirements of subsection (a) of this section may include any of the following entities for *access to and coordination with direct* service providers and to facilitate access to flexible services and other community and support services:

(1) A carrier;

(2) An administrative entity;

(3) A federally qualified *health center;*

(4) A rural health clinic;

(5) An associated participant; or

(6) Any other type of direct service provider that delivers or is qualified to deliver healthcare services to *enrollable* Medicaid beneficiary populations.

(c) A risk-based provider organization may provide healthcare services directly to *enrollable* Medicaid beneficiary populations or through:

(1) A direct service provider that is a participating provider in the risk-based provider organization;

(2) A direct service provider subcontracted by the risk-based provider organization; or

(3) An independent provider that enters into a provider agreement or business relationship with a direct service provider.

(d)(1) Except as provided in subdivision (d)(2) of this section, reimbursement rates paid by a risk-based provider organization to direct service providers shall:

(A) Be determined by mutual agreement of the risk-based provider organization and direct service provider without regard to Medicaid *provider rates established by the Department of Human Services; and*

(B) Assure efficiency, economy, quality, and equal access *to enrollable Medicaid beneficiary populations in the same manner as to individuals who are not covered by the Arkansas Medicaid Program.*

(2) The reimbursement rates established by a risk-based provider organization shall not be subject to any administrative review by the *Insurance Commissioner.*

(3) A risk-based provider organization may contract with a Community Pharmacy Enhanced Services Network to provide enhanced pharmacist services to manage complex patients at a mutually agreed upon rate schedule.

(e)(1) Except as provided in subdivision (e)(2) of this section, all policies and procedures regarding the provision of healthcare services by a direct service provider shall:

(A) Be determined by mutual agreement of the risk-based provider organization and the direct service provider without regard to *Medicaid provider rates established by the Department of Human Services; and*

(B) Assure efficiency, economy, quality, and equal access *to the enrollable Medicaid beneficiary population in the same manner as individuals who are not covered by the Arkansas Medicaid Program*

(2) A direct service provider that is delivering services to the *enrollable* Medicaid beneficiary populations shall:

(A) Meet any licensing or certification requirements set by law or rule; and

(B) Not otherwise be disqualified from participating in the Arkansas Medicaid Program or Medicare.

(f) Upon licensure by the commissioner, a risk-based provider organization shall perform the following functions:

(1) Enroll members of *enrollable* Medicaid beneficiary populations into the risk-based provider organization and remove members of *enrollable* Medicaid beneficiary populations from the risk-based provider organization;

(2) Ensure the following:

(A) Protection of beneficiary rights and due process in accordance with federally mandated regulations governing Medicaid managed care organizations;

(B) Proper credentialing of direct service providers in *accordance with state and federal requirements;*

(C) Care coordination of members enrolled into the risk-*based provider organization; and*

(D) A consumer advisory council consisting of consumers of developmental disability services and behavioral health services, including substance abuse treatment and services;

(3) Process claims or otherwise ensure payment to direct service providers within time frames established under federal regulations for goods and services delivered to the *enrollable* Medicaid beneficiary populations;

(4) Maintain the following:

(A) A network of direct service providers sufficient to ensure that all services to recipients are adequately accessible within time and distance requirements defined by the state; and

(B) A reserve of six million dollars ($6,000,000) and an additional amount as determined by the commissioner at the initial licensure based upon the risk assumed and the projected liabilities under standards promulgated by rules of the State Insurance Department;

(5) Comply with all data collection and reporting requirements established by the commissioner;

(6) Provide the following:

(A) Financial reports and information to the commissioner *as required by the commissioner in rules applicable to risk-based provider organizations; and*

(B) Practice and clinical support to direct service providers; and

(7) Manage the following:

(A)(i) Global capitated payments and the attendant financial risks for delivery of services to the *enrollable* Medicaid beneficiary populations.

(ii) The Department of Human Services shall develop actuarially sound capitated rates for a defined scope of services under a *risk methodology that may include risk adjustments, reinsurance, and stop-loss* funding methods; and

(B)(i) Incentive payments received from the Department of Human Services when quality and outcome measures are achieved.

(ii) The Department of Human Services shall develop rules, in consultation with direct service providers for individuals with behavioral health needs and individuals with intellectual and development disabilities, establishing criteria for quality incentive payments to encourage and reward delivery of high-quality care and services by a risk-based provider organization.

20-77-2707. Reporting and performance measures.

(a)(1) On a quarterly basis, a risk-based provider organization shall submit to the Department of Human Services protected health information for *each member of a covered Medicaid beneficiary population and a voluntary Medicaid beneficiary population enrolled with the* risk-based provider organization in accordance with standards and procedures adopted by the department, including without limitation:

(A) Claims data, including without limitation:

(i) Denial rates; and

(ii) Claims-paid rates;

(B) Encounter data;

(C) Unique identifiers;

(D) Geographic and demographic information;

(E) Patient satisfaction scores; and

(F) Other information as required by the state.

(2) Personally identifiable data submitted under this section shall be treated as confidential and is exempt from disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq.

(b) The department shall use the data submitted under subsection (a) of this section to measure the performance of the risk-based provider organization in:

(1) Delivery of services;

(2) Patient outcomes;

(3) Efficiencies achieved; and

(4) Quality measures.

(c) Performance measures established by the department shall at a minimum monitor:

(1) Reduction in unnecessary hospital emergency department utilization;

(2) Adherence to prescribed medication regimens;

(3) Reduction in avoidable hospitalizations for ambulatory-sensitive conditions; and

(4) Reduction in hospital readmissions.

(d) The department shall issue funds from the quality incentive pool above the amount of the global payments initially provided to a risk-based provider organization that meets or exceeds specific performance and outcome measures established by the department.

(e) On *a quarterly basis*, the department shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding:

(1) Risk-based provider organization membership enrollment and distribution;

(2) Patient experience data; and

(3) Financial performance, including demonstrated savings.

20-77-2708. Waiver and rulemaking authority.

The Department of Human Services:

(1) Shall submit an application for any federal waivers, federal authority, or state plan amendments necessary to implement this subchapter;

and

(2) May promulgate rules as necessary to implement this subchapter.

SECTION 2. Arkansas Code § 19-5-985(b)(1), concerning the Arkansas Medicaid Program Trust Fund, is amended to read as follows:

(b)(1) The fund shall consist of the following:

(A) All revenues derived from taxes levied on soft drinks sold or offered for sale in Arkansas under the Arkansas Soft Drink Tax Act, § 26-57-901 et seq., there to be used exclusively for the state match of federal funds participation under the Arkansas Medicaid Program;

(B) The additional ambulance annual fees stated in § 20-13-212;

(C) The special revenues specified in §§ 19-6-301(156) and 19-6-301(236); ~~and~~

(D) Payments from surety bonds issued regarding risk-based provider organizations, as defined in § 20-77-2703; and

(E) The amounts collected under §§ 26-57-604 and 26-57-605 above the forecasted level for insurance premium taxes set by the Chief Fiscal Officer of the State under § 10-3-1404(a)(1)(A).

SECTION 3. Arkansas Code Title 23, Chapter 61, Subchapter 1, is amended to add an additional section to read as follows:

23-61-117. Risk-based provider organizations.

(a) The Insurance Commissioner shall regulate the licensing and financial solvency of risk-based provider organizations, as defined in § 20-77-2703, participating in the Medicaid provider-led organized care system for *enrollable* Medicaid beneficiary populations as defined in § 20-77-2703.

(b) The commissioner may:

(1) Issue rules to implement this section;

(2) Impose and collect a reasonable fee from a risk-based provider organization for the regulation and licensing of the risk-based provider organization as established by rule of the State Insurance Department; and

(3)(A) Administer collection of *the quarterly tax* imposed on risk-based provider organizations under § 26-57-603 pursuant to a rule issued

by the department.

(B) The commissioner shall prescribe the reporting, forms, and requirements related to the payment of *the quarterly tax* in a rule issued by the department.

SECTION 4. Arkansas Code § 26-57-603, concerning tax reports and the insurance premium tax, is amended to add an additional subsection to read as follows:

(f)(1) A risk-based provider organization that is licensed under the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq., and § 23-61-117 and participates in the Medicaid provider-led organized care system offered by the Arkansas Medicaid Program for *enrollable* Medicaid beneficiary populations as defined in § 20-77-2703 shall pay to the Treasurer of State through the commissioner a tax imposed for the privilege of transacting business in this state.

(2) The tax shall be computed at a rate of two and one-half percent (2½%) on the total amount of funds received in global payments as defined under § 20-77-2703 to a risk-based provider organization participating in the Medicaid provider-led organized care system.

(3) The tax shall be:

(A) Reported at such times and in such form and context as prescribed by the commissioner; and

(B) Paid on a quarterly basis as prescribed by the commissioner.

SECTION 5. Arkansas Code § 26-57-604(a)(1)(B), concerning the remittance of insurance premium tax and credit for noncommissioned salaries and wages of employees of the insurers, is amended to add an additional subdivision to read as follows:

(iii) The credit shall not be applied as an offset against the premium tax on collections resulting from an eligible individual insured under the Arkansas Medicaid Program as administered by a risk-based provider organization.

SECTION 6. Arkansas Code § 26-57-610(b), concerning the disposition of the insurance premium tax, is amended to add an additional subdivision to

read as follows:

(5) The taxes based on premiums collected under the Arkansas Medicaid Program as administered by a risk-based provider organization 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;

(B)(i) Transferred in amounts not less than fifty percent (50%) of the taxes based on premiums collected under the Arkansas Medicaid Program as administered by a risk-based provider organization to the designated account created by § 20-48-1004 within the Arkansas Medicaid Program Trust Fund to solely provide funding for home and community-based services to individuals with intellectual and developmental disabilities until the Department of Human Services certifies to the Department of Finance and Administration that the waiting list for the Alternative Community Services Waiver Program, also known as the "Developmental Disabilities Waiver", is eliminated.

(ii) On and after the certification as described in subdivision (b)(5)(B)(i) of this section, all amounts of the taxes based on premiums collected under the Arkansas Medicaid Program as administered by a risk-based provider organization shall be transferred as described in subdivision (b)(5)(C) of this section; and

(C) On and after the certification as described in subdivision (b)(5)(A) of this section and after the transfer under subdivision (b)(5)(B)(i) of this section, transferred in the remainder to the Arkansas Medicaid Program Trust Fund and used as provided by § 19-5-985 as well as being used to provide funding for:

(i) The quality incentive pool under § 20-77-2701 et seq.;

(ii) Home and community-based services for *individuals with behavioral health needs and intellectual and developmental disabilities; and*

(iii) Other services covered by the Arkansas Medicaid Program as determined by the Department of Human Services.

SECTION 7. DO NOT CODIFY. Implementation of Medicaid Provider-Led

Organized Care Act.

(a) The Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq., shall be implemented as follows:

(1) On or before June 1, 2017, the Insurance Commissioner shall adopt rules for the licensure of risk-based provider organizations to implement the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq.;

(2)(A) On or before July 1, 2017, an organization seeking conditional licensure in state for fiscal year 2018 to become a risk-based provider organization shall submit an application to the commissioner.

(B) An organization may receive conditional license as a risk-based provider organization upon demonstration of a governing board and sufficient agreements with various providers of medical goods and services.

(C) A license issued conditionally shall expire on December 31, 2017, or a later date as established by the commissioner;

(3) On or before October 1, 2017, an organization with conditional license shall:

(A) Be capable of enrolling members of *enrollable* Medicaid beneficiary populations into the risk-based organization;

(B) Demonstrate to the approval of the commissioner the ability to establish an adequate medical service delivery network; and

(C)(i) Provide evidence of a bond issued by a surety authorized to do business in this state in the amount of two hundred fifty thousand dollars ($250,000).

(ii) The bond shall provide that the surety and the organization shall be jointly and severally liable for payment of the bond amount in the event the organization abandons efforts to obtain full licensure.

(iii) Any payouts on a bond issued under this section shall be paid to the Arkansas Medicaid Program Trust Fund;

(4) On or before January 1, 2018, an organization with conditional license shall demonstrate to the commissioner that it has met the solvency and financial requirements for a risk-based organization as established by the commissioner; and

(5) On or before April 1, 2018, or a later date established by the commissioner, an organization with conditional license shall demonstrate to the commissioner that the organization is capable of assuming the risk of

a global payment and arranging for provision of healthcare services to the *enrollable* Medicaid beneficiary populations.

(b)(1) Failure to comply with any one (1) of the milestones outlined in subsection (a) of this section shall be grounds for termination of a conditional licensure or full licensure.

(2) The commissioner shall award full licensure to a risk-based provider organization with conditional licensure if the organization timely meets each of the milestones outlined in subsection (a) of this section.

(3) Failure by an organization to timely meet one (1) or more of the milestones outlined in subsection (a) of this section shall not prevent the commissioner, in his or her sole discretion, from granting full licensure to the organization as long as the organization has met all of the milestones outlined in subsection (a) of this section by January 1, 2018, or a later date established by the commissioner.

(c) Implementation of the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq., shall not be considered a rule under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

SECTION 8. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that the current method of serving the *enrollable* Medicaid beneficiary populations is resulting in excessive and unnecessary costs to the Arkansas Medicaid Program and to the State of Arkansas; that the *enrollable* Medicaid beneficiary populations are growing at a rate that is unsustainable under the current method of serving the *enrollable* Medicaid beneficiary populations; that the Medicaid provider-led organized care system will improve quality and efficiencies of healthcare services to *enrollable* Medicaid beneficiary populations by enhancing the performance of the broader healthcare system with increased access to care; that the Medicaid Provider-Led Organized Care Act requires healthcare providers to create, present to the Department of Human Services and the Insurance Commissioner for approval, implement, and market a new kind of organization that offers a type of health insurance; and that this act is immediately necessary to ensure efficient use of taxpayer dollars and to provide healthcare providers certainty about the law creating the Medicaid Provider-Led Organized Care Act before fully investing time, funds, personnel, and other resources to the development of the new risk-based

provider organizations. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/Pilkington

APPROVED: 03/31/2017