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# A Bill

3 Regular Session, 2017

HOUSE BILL 1706

4

5 By: Representatives Pilkington, Davis, Collins, Brown, G. Hodges

6 By: Senator J. Cooper

7

8

## For An Act To Be Entitled

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

17

18

19

## Subtitle

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

26

27

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

30

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

34

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

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



1 state law to beneficiaries who are individuals with disabilities;

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

4 (3) Allow an individual with disabilities to:

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

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

11  
12 WHEREAS, the State of Arkansas wishes to affirm the commitment to the  
13 principles of full and equal treatment and unlimited opportunities for all  
14 Arkansans that are afforded, as of February 1, 2017, to individuals with  
15 disabilities as a basic tenet of this legislation,

16  
17 NOW THEREFORE,

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

19  
20 SECTION 1. Arkansas Code Title 20, Chapter 77, is amended to add an  
21 additional subchapter to read as follows:

22 Subchapter 27 – Medicaid Provider-Led Organized Care Act

23  
24 20-77-2701. Title.

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

27  
28 20-77-2702. Legislative intent and purpose.

29 (a) As the single state agency for administration of the medical  
30 assistance programs established under Title XIX of the Social Security Act,  
31 42 U.S.C. § 1396 et seq., and Title XXI of the Social Security Act, 42 U.S.C.  
32 § 1397aa et seq., the Department of Human Services is authorized by federal  
33 law to utilize one (1) or more organizations for providing healthcare  
34 services to Medicaid beneficiary populations.

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

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

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

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

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

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

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

15 (5) Discourage excessive use of services;

16 (6) Reduce waste, fraud, and abuse;

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

18 (8) Operate under federal guidelines for patient rights.

19  
20 20-77-2703. Definitions.

21 As used in this subchapter:

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

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

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

33 (B) "Care coordination" includes without limitation:

34 (i) Health education and coaching;

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

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

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

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

8 (vii) Community-based management of medication  
9 therapy;

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

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

13 (B) Authorized to provide healthcare plans under § 23-76-  
14 108 as a health maintenance organization; or

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

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

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

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

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

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

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

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

3 (B) Members of a voluntary Medicaid beneficiary  
4 population;

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

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

16 (10) "Medicaid" means the programs authorized under Title XIX of  
17 the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XXI of the  
18 Social Security Act, 42 U.S.C. § 1397aa et seq., as they existed on January  
19 1, 2017, for the provision of healthcare services to members of enrollable  
20 Medicaid beneficiary populations;

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

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

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

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

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

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

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

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

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

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

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

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

15  
16 20-77-2704. Licensure by Insurance Commissioner.

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

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

24  
25 20-77-2705. Excluded services.

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

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

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

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

1 (1) Nonemergency medical transportation in a capitated program;  
2 (2) Dental benefits in a capitated program;  
3 (3) School-based services provided by school employees;  
4 (4) Skilled nursing facility services;  
5 (5) Assisted living facility services;  
6 (6) Human development center services; or  
7 (7) Waiver services provided to adults with physical  
8 disabilities through the ARChoices in Homecare program or the Arkansas  
9 Independent Choices program.

10 20-77-2706. Characteristics and duties of risk-based provider  
11 organization.

12 (a) A risk-based provider organization shall:

13 (1) Be authorized to conduct business in the state;  
14 (2) Hold a valid certificate of authority issued by the  
15 Secretary of State;  
16 (3) Have ownership interest of not less than fifty-one percent  
17 (51%) by participating providers; and

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

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

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

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

26 (D) An Arkansas licensed physician practice; and

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

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

33 (1) A carrier;  
34 (2) An administrative entity;  
35 (3) A federally qualified health center;  
36 (4) A rural health clinic;

1 (5) An associated participant; or

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

13                   (2) Ensure the following:

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

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

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

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

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

27                   (4) Maintain the following:

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

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

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

1 (6) Provide the following:

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

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

7 (7) Manage the following:

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

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

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

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

23  
24 20-77-2707. Reporting and performance measures.

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

31 (A) Claims data, including without limitation:

32 (i) Denial rates; and

33 (ii) Claims-paid rates;

34 (B) Encounter data;

35 (C) Unique identifiers;

36 (D) Geographic and demographic information;

- 1                   (E) Patient satisfaction scores; and  
2                   (F) Other information as required by the state.  
3                   (2) Personally identifiable data submitted under this section  
4 shall be treated as confidential and is exempt from disclosure under the  
5 Freedom of Information Act of 1967, § 25-19-101 et seq.  
6                   (b) The department shall use the data submitted under subsection (a)  
7 of this section to measure the performance of the risk-based provider  
8 organization in:  
9                   (1) Delivery of services;  
10                   (2) Patient outcomes;  
11                   (3) Efficiencies achieved; and  
12                   (4) Quality measures.  
13                   (c) Performance measures established by the department shall at a  
14 minimum monitor:  
15                   (1) Reduction in unnecessary hospital emergency department  
16 utilization;  
17                   (2) Adherence to prescribed medication regimens;  
18                   (3) Reduction in avoidable hospitalizations for ambulatory-  
19 sensitive conditions; and  
20                   (4) Reduction in hospital readmissions.  
21                   (d) The department shall issue funds from the quality incentive pool  
22 above the amount of the global payments initially provided to a risk-based  
23 provider organization that meets or exceeds specific performance and outcome  
24 measures established by the department.  
25                   (e) On a quarterly basis, the department shall report to the  
26 Legislative Council, or to the Joint Budget Committee if the General Assembly  
27 is in session, available information regarding:  
28                   (1) Risk-based provider organization membership enrollment and  
29 distribution;  
30                   (2) Patient experience data; and  
31                   (3) Financial performance, including demonstrated savings.  
32  
33                   20-77-2708. Waiver and rulemaking authority.  
34                   The Department of Human Services:  
35                   (1) Shall submit an application for any federal waivers, federal  
36 authority, or state plan amendments necessary to implement this subchapter;

1 and

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

4  
5 SECTION 2. Arkansas Code § 19-5-985(b)(1), concerning the Arkansas  
6 Medicaid Program Trust Fund, is amended to read as follows:

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

8 (A) All revenues derived from taxes levied on soft drinks  
9 sold or offered for sale in Arkansas under the Arkansas Soft Drink Tax Act, §  
10 26-57-901 et seq., there to be used exclusively for the state match of  
11 federal funds participation under the Arkansas Medicaid Program;

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

14 (C) The special revenues specified in §§ 19-6-301(156) and  
15 19-6-301(236); ~~and~~

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

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

21

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

24 23-61-117. Risk-based provider organizations.

25 (a) The Insurance Commissioner shall regulate the licensing and  
26 financial solvency of risk-based provider organizations, as defined in § 20-  
27 77-2703, participating in the Medicaid provider-led organized care system for  
28 enrollable Medicaid beneficiary populations as defined in § 20-77-2703.

29 (b) The commissioner may:

30 (1) Issue rules to implement this section;

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

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

1 by the department.

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

5  
6 SECTION 4. Arkansas Code § 26-57-603, concerning tax reports and the  
7 insurance premium tax, is amended to add an additional subsection to read as  
8 follows:

9 (f)(1) A risk-based provider organization that is licensed under the  
10 Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq., and § 23-61-  
11 117 and participates in the Medicaid provider-led organized care system  
12 offered by the Arkansas Medicaid Program for *enrollable* Medicaid beneficiary  
13 populations as defined in § 20-77-2703 shall pay to the Treasurer of State  
14 through the commissioner a tax imposed for the privilege of transacting  
15 business in this state.

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

20 (3) The tax shall be:

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

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

25  
26 SECTION 5. Arkansas Code § 26-57-604(a)(1)(B), concerning the  
27 remittance of insurance premium tax and credit for noncommissioned salaries  
28 and wages of employees of the insurers, is amended to add an additional  
29 subdivision to read as follows:

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

34  
35 SECTION 6. Arkansas Code § 26-57-610(b), concerning the disposition of  
36 the insurance premium tax, is amended to add an additional subdivision to

1 read as follows:

2 (5) The taxes based on premiums collected under the Arkansas  
3 Medicaid Program as administered by a risk-based provider organization shall  
4 be:

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

8 (B)(i) Transferred in amounts not less than fifty percent  
9 (50%) of the taxes based on premiums collected under the Arkansas Medicaid  
10 Program as administered by a risk-based provider organization to the  
11 designated account created by § 20-48-1004 within the Arkansas Medicaid  
12 Program Trust Fund to solely provide funding for home and community-based  
13 services to individuals with intellectual and developmental disabilities  
14 until the Department of Human Services certifies to the Department of Finance  
15 and Administration that the waiting list for the Alternative Community  
16 Services Waiver Program, also known as the "Developmental Disabilities  
17 Waiver", is eliminated.

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

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

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

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

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

35

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

1 Organized Care Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (c) Implementation of the Medicaid Provider-Led Organized Care Act, §  
16 20-77-2701 et seq., shall not be considered a rule under the Arkansas  
17 Administrative Procedure Act, § 25-15-201 et seq.

18  
19 SECTION 8. EMERGENCY CLAUSE. It is found and determined by the  
20 General Assembly of the State of Arkansas that the current method of serving  
21 the enrollable Medicaid beneficiary populations is resulting in excessive and  
22 unnecessary costs to the Arkansas Medicaid Program and to the State of  
23 Arkansas; that the enrollable Medicaid beneficiary populations are growing at  
24 a rate that is unsustainable under the current method of serving the  
25 enrollable Medicaid beneficiary populations; that the Medicaid provider-led  
26 organized care system will improve quality and efficiencies of healthcare  
27 services to enrollable Medicaid beneficiary populations by enhancing the  
28 performance of the broader healthcare system with increased access to care;  
29 that the Medicaid Provider-Led Organized Care Act requires healthcare  
30 providers to create, present to the Department of Human Services and the  
31 Insurance Commissioner for approval, implement, and market a new kind of  
32 organization that offers a type of health insurance; and that this act is  
33 immediately necessary to ensure efficient use of taxpayer dollars and to  
34 provide healthcare providers certainty about the law creating the Medicaid  
35 Provider-Led Organized Care Act before fully investing time, funds,  
36 personnel, and other resources to the development of the new risk-based



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

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

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

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

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11 */s/Pilkington*  
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