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A Bill

DRAFT JMB/JMB
HOUSE BILL

By: Representatives M. Gray, Boyd, D. Ferguson, Farrer
By: Senators Irvin, J. Cooper, K. Ingram, L. Chesterfield

For An Act To Be Entitled

AN ACT TO CREATE THE DIAMONDCARE ACT OF 2016; TO IMPLEMENT MANAGED FEE-FOR-SERVICES ON CERTAIN MEDICAID POPULATIONS; TO REFORM THE ARKANSAS MEDICAID PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

TO CREATE THE DIAMONDCARE ACT OF 2016; TO IMPLEMENT MANAGED FEE-FOR-SERVICES ON CERTAIN MEDICAID POPULATIONS; AND TO REFORM THE ARKANSAS MEDICAID PROGRAM.

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 — Diamondcare Act of 2016

20-77-2701. Title.

This subchapter shall be known and may be cited as the "Diamondcare Act of 2016".

20-77-2702. Legislative intent.

(a) It is the intent of the General Assembly to:

(1) Fundamentally redesign the Arkansas Medicaid Program in order to achieve a person-centered and opportunity-driven program;

(2) Ensure that the Arkansas Medicaid Program is a:

(A) Sustainable, cost-effective, person-centered, and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options; and

(B) Results-oriented system of coordinated care that:

(i) Focuses on independence and choice;

(ii) Maximizes available service options;

(iii) Promotes accountability and transparency;

(iv) Encourages and rewards healthy outcomes and responsible choices; and

(v) Promotes efficiencies through interdepartmental cooperation.

20-77-2703. Definitions.

As used in this subchapter:

(1) "Administrative services organization" means an organization that provides outsourced solutions to meet the administrative needs or human resource needs, or both, of a contracting entity, including without limitation
claims processing and billing;

(2) "Assertive community treatment" means an evidence-based mental health service that is provided by a multidisciplinary team to an identified participant group in the community;

(3) "Brief intervention services" means short-term services for adults seeking assistance with high-risk behavioral health issues, including without limitation:

(A) Assessment and evaluation;

(B) Triage;

(C) Referral; and

(D) Time-limited outpatient services;

(4) "Capitated" means a healthcare payment methodology that is based on a payment per person that covers the total risk for providing all healthcare services for a person;

(5) "Child and Adolescent Needs and Strengths Assessment Instrument" means the multipurposed instrument developed for services for children that is used to:

(A) Align the assessment process with an individualized

plan of care;

(B) Support decision-making regarding level of care and service planning;

(C) Facilitate quality improvement initiatives; and

(D) Allow for monitoring of outcomes;

(6) "Cost cap" means an upper limit on what the Arkansas Medicaid Program pays for a specific service;

(7) "Developmental day treatment clinic services" means comprehensive day treatment services provided in a clinical setting to individuals with a developmental disability or an intellectual disability, or both;

(8) "Diagnosis-related group methodology" means a system of classification of diagnoses and procedures based on the International Classification of Diseases, Tenth Revision, Clinical Modification, also known as ICD-10-CM, including without limitation:

(A) The all-patient refined diagnosis-related groups system; and

(B) The enhanced ambulatory procedure grouping system;

(9) "Dialectical behavior therapy" means evidence-based cognitive behavioral therapy developed to improve the treatment of individuals with self-harming behavior and borderline personality disorder by changing patterns of behavior and increasing the capacity of an individual to tolerate stress;

(10) "Early and periodic screening, diagnostic, and treatment" means the comprehensive array of prevention services, diagnostic services, and treatment services mandated for low-income infants, children, and adolescents under twenty-one (21) years of age under 42 U.S.C. § 1396d(r), as it existed on January 1, 2016;

(11) "Global waiver" means a federal waiver under section 1115 of the Social Security Act, 42 U.S.C. § 1315, that establishes a comprehensive approach to a state Medicaid program that merges all existing federal waivers into one (1) federal waiver and makes programmatic changes in one (1) federal waiver;

(12) "Habilitation services" means services designed to help an individual gain skills to increase independence and improve the ability to live in a community, including without limitation:

(A) Prevocational services;

(B) Educational services; and

(C) Supported employment services;

(13) "Health home" means the healthcare model of coordinated care for individuals with chronic conditions, including mental health and substance use disorders, as defined by 42 U.S.C. § 1396w-4, as it existed on January 1, 2016;

(14) "Independent assessment" means a needs-based assessment conducted by a qualified professional who does not have a financial interest in the care of a Medicaid eligible individual to identify the needs, level of care, and cost to be addressed in a person-centered plan for the eligible individual;

(15) "Intermediate care facility for developmental disabilities" means a facility that provides comprehensive and individualized healthcare and habilitation services to individuals with developmental disabilities to promote independence and that is:

(A) Available only for individuals in need of and receiving active treatment; and

(B) Based on the individualized program plan evaluated by an interdisciplinary team;

(16) "InterRai" means a modularized assessment specialized for long-term care that allows for the functional and clinical assessment of individuals living in a range of settings across the continuum of care;

(17) "Level of acuity" means the result of an assessment that determines the needs of an individual for healthcare services;

(18) "Level of Care Utilization System Assessment Instrument" means an assessment and level of care instrument designed by the American Association of Community Psychiatrists that addresses the needs of an individual based on level of functionality, diagnosis, and psychiatric risk;

(19) "Managed care organization" means an entity that is:

(A) Obligated under a comprehensive full-risk contract with the Department of Human Services to provide all medically necessary goods and services to a defined group of Medicaid beneficiaries;

(B) Paid by the Department of Human Services on a capitated basis, with payment made regardless of whether a particular beneficiary receives services during the period covered by the payment; or

(C) An organization authorized to operate in this state under the Arkansas Insurance Code and the rules of the State Insurance Department;

(19) "Managed fee-for-service organization model" means the management of only administrative services by an administrative services organization, including without limitation:

(A) Independent assessment;

(B) Prior authorization;

(C) Plan of care;

(D) Utilization management;

(E) Quality assurance;

(F) Outcomes measurement;

(G) Call center services;

(H) High-cost care management and care coordination; and

(I) Cost comparison to a specific benchmark;

(20) "Medical loss ratio" means the total amount that a health plan spends on payments for healthcare services divided by the total premium revenues received to cover the service payments;

(21) "Multisystemic therapy" means an intensive evidence-based therapy for youth and families that focuses on addressing all environment systems that affect an individual who has a chronic mental health and violence issue or is at risk for developing a chronic mental health and violence issue;

(22) "Person-centered planning" means a process that addresses needed healthcare services and supports for an individual in a manner that reflects the personal preferences and goals of the individual;

(22) "Supports Intensity Scale™" means the assessment instrument that measures the support needs of an individual in personal, work-related, and social activities to identify the types and intensity of the services and supports that the individual needs;

(23) "Utilization review" means a system of review that determines the appropriate and efficient allocation of healthcare resources and medical services given or proposed to be given to a patient or group of patients; and

(24)(A) "Value-based purchasing strategy" means a broad set of payment strategies that link financial incentives to the healthcare delivery

performance of a healthcare provider on a set of defined performance measures that are designed to improve quality or reduce costs, or both.

(B) "Value-based purchasing strategy" includes contractual arrangements that provide for healthcare providers to receive:

(i) A bonus payment for measureable performance in quality, patient satisfaction, resource use, and cost; and

(ii) Lower payments for events and procedures that:

(a) Were avoidable;

(b) Do not promote quality; and

(c) Increase costs.

20-77-2704. Managed fee-for-service organization model.

(a) The Department of Human Services shall:

(1)(A) Employ a managed fee-for-service organization model for administering the Arkansas Medicaid Program for the following populations of individuals receiving:

(i) Developmental disability services as defined by the department;

(ii) Behavioral health services as defined by the department;

(iii) Rehabilitative services for persons with mental illness; and

(iv) Treatment through an inpatient psychiatric hospital or a residential treatment center.

(B) An individual residing in either a human development center within the state or the Arkansas State Hospital shall not be covered by the managed fee-for-service organization model; and

(2) Enter into contracts with one (1) or more administrative services organizations that demonstrate the greatest ability to satisfy the need for value, quality, positive outcomes, efficiency, innovation, and savings.

(b) The managed fee-for-service organization model shall provide for, at a minimum:

(1) Independent assessments for developmental disabilities and behavioral health services;

(2) Individual plans of care and care coordination for high-cost

beneficiaries;

(3) Prior authorization; and

(4) Utilization management and disease management related to population health improvements.

(c) The managed fee-for-service organization model shall:

(1) Offer the best value available for purchase for the Medicaid beneficiaries as described in subdivision (a)(1)(A) of this section;

(2) Assure person-centered planning;

(3) Provide beneficiary choice of healthcare providers;

(4) Address population health issues, quality assurance issues, and efficiency issues; and

(5) Maximize the potential for savings within the traditional Arkansas Medicaid Program.

20-77-2705. Patient-centered medical home program.

(a) The managed fee-for-service organization model shall provide connection to the Arkansas Patient-Centered Medical Home Program.

(b) The Department of Human Services shall:

(1) Establish a mechanism for identifying and coordinating the care of Medicaid beneficiaries with high-cost medical cases and complex medical cases through a patient-centered medical home;

(2) Identify:

(A) Services currently excluded from the cost calculations for the Arkansas Patient-Centered Medical Home Program; and

(B) Medicaid beneficiaries with high claim costs who are not:

(i) Individuals sixty-five (65) years of age and older;

(ii) Individuals with physical disabilities or developmental disabilities; or

(iii) Individuals with severe and persistent mental illness; and

(3)(A) Develop a strategy for care management and care coordination for services and individuals identified under subdivision (b)(2) of this section.

(B) The strategy for care management and care coordination

may include without limitation:

(i) Expansion or modification of the existing Arkansas Patient-Centered Medical Home Program; or

(ii) Contracting with an independent entity for care management and care coordination with a determined level of risk.

(c) On or before October 1 of each year, the department shall report to the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor regarding the expansion or modification of the patient-centered medical home.

20-77-2706. Dental managed care.

(a)(1) The Department of Human Services shall enter into a comprehensive full-risk contract with one (1) or more managed care organizations to administer dental benefits to all Medicaid beneficiaries statewide.

(2) A managed care organization that submits a bid or proposal to provide dental services may not submit a bid or proposal as an administrative services organization under § 20-77-2704.

(3) The department shall set the appropriate medical loss ratio in accordance with state law and federal law.

20-77-2707. Monitoring of quality of care — Financial risk.

(a) The Department of Human Services shall monitor the administrative services organizations of the managed fee-for-service organization model and the managed care organization to ensure that:

(1) A reduction in the quality of care provided to Medicaid beneficiaries as described in § 20-77-2704(a)(1)(A) does not occur; and

(2) The current level of quality of care provided to Medicaid beneficiaries as described in § 20-77-2704(a)(1)(A) is either maintained or increased.

(b) If a reduction in the quality of care provided to Medicaid beneficiaries as described in § 20-77-2704(a)(1)(A) occurs or a failure to meet contracted benchmark savings established by the department occurs, the department shall require that administrative services organizations or the managed care organization pay a contracted administrative fee as a financial risk.

(c) The department shall develop a methodology to allow for incentive payments to an administrative services organization of the managed fee-for-service organization model or the managed care organization upon meeting contracted benchmarks.

20-77-2708. Value-based purchasing strategy.

(a) The Department of Human Services shall develop and implement a comprehensive value-based purchasing strategy to ensure that the state receives the highest possible value when purchasing healthcare services through the Arkansas Medicaid Program in accordance with the purchasing laws of Arkansas, including without limitation § 19-11-101 et seq. and the Arkansas Procurement Law, § 19-11-201 et seq.

(b) The value-based purchasing strategy may be implemented through the Arkansas Medicaid Program, including without limitation:

(1) Existing healthcare programs and strategies, including without limitation the Arkansas Patient-Centered Medical Home Program and the various episodes of care; and

(2) New healthcare programs and strategies, including without limitation:

(A) Quality reporting for Medicaid providers;

(B) Health homes for Medicaid beneficiaries who are:

(i) More than sixty-five (65) years of age;

(ii) Diagnosed with a physical disability or a developmental disability, or both; or

(iii) Diagnosed with severe and persistent mental illness;

(C) Reimbursement withholding pending satisfactory achievement on healthcare provider performance measures; and

(D) Shared savings and shared risks for Medicaid providers.

20-77-2709. Project management.

(a) Within ninety-five (95) days of the enactment date of this section, the Department of Human Services shall submit an implementation plan for the reform model of the traditional Arkansas Medicaid Program to the Governor, the Legislative Council, the Senate Committee on Public Health,

Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor.

(b) After the implementation plan is submitted, the department shall submit quarterly an implementation progress report to the Governor, the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor.

(c) Both the implementation plan and the implementation progress report shall describe:

(1) The current status of the implementation;

(2) The anticipated timeline for the implementation;

(3) Any major milestones achieved;

(4) All implementation risks; and

(5) Any changes to the timeline described in subdivision (c)(2) of this section.

20-77-2710. Dashboard for operation metrics.

(a) The Department of Human Services shall develop an online dashboard for the reporting of budget data, program performance data, and population health data regarding the Arkansas Medicaid Program.

(b) The online dashboard shall include without limitation:

(1) The number of applications received and processed;

(2) The total enrollment numbers by eligibility group;

(3) The new enrollment numbers by eligibility group since the last reporting;

(4) The amount and number of paid claims by eligibility group;

(5) The number of payments made for healthcare services associated with labor and delivery;

(6) Medicaid provider performance measures;

(7) Performance metrics for key contracts with the program;

(8) Performance of all major savings initiatives contained in this subchapter and any other program reform measures;

(9) Budget trend analysis for all Medicaid healthcare services spending, including all categories of Medicaid providers; and

(10) Medicaid beneficiary population health data, including without limitation information on diabetes, prescription adherence, and obesity.

(c)(1) Within nintey-five (95) days of the enactment date of this section, the department shall submit the online dashboard to the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor for review.

(2) The Legislative Council meeting in conjunction with the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor may request changes to the online dashboard.

(3) The department shall implement the online dashboard on or before January 1, 2017.

(d) The department shall update the online dashboard no less than monthly.

20-77-2711. Diagnosis-related group methodology for hospitals.

(a) To the extent possible, the Department of Human Services shall convert the hospital reimbursement systems under the Arkansas Medicaid Program to a diagnosis-related group methodology to allow more accurate classification of patient populations and description of mortality risks and severity of patient illness.

(b)(1) The department shall promulgate rules to implement this section.

(2) The rules under subdivision (b)(1) of this section shall address:

(A) How supplemental payments to hospitals shall be considered;

(B) Whether funding for the transition from per diem reimbursement to diagnosis-related group methodology shall be provided to hospitals; and

(C) Whether certain types of hospital providers shall be exempt from the diagnosis-related group methodology.

(d)(1) The department, in coordination with the Arkansas Hospital Association, shall develop a plan for the conversion of the hospital reimbursement systems under the Arkansas Medicaid Program as described in subsection (b) of this section.

(2) The conversion plan shall:

(A) Include estimates of the impact of the conversion on

all state and federal funds used for hospital payment, including without limitation any impact on critical-access hospitals; and

(B) Be submitted to the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor for review within ninety-five (95) days of the enactment date of this section.

20-77-2712. Independent annual Medicaid provider rate review.

(a)(1) An independent annual Medicaid provider rate review shall be conducted by an independent consultant with demonstrable experience in Medicaid rate-setting methods and the Healthcare Common Procedure Coding System and the Current Procedure Terminology codes set out by the Centers for Medicare and Medicaid Services.

(2)(A) The independent annual Medicaid provider rate review shall consist of a review of one-third (1/3) of the total billing codes for providers.

(B) All billing codes shall be reviewed one (1) time every three (3) years.

(b)(1) The Department of Human Services shall issue a request for proposals for the independent annual Medicaid provider rate review described in subsection (a) of this section.

(2) The vendor chosen shall compare Medicaid services payment rates by billing code designation to comparable services paid by:

(A) Other state Medicaid programs;

(B) Medicare; and

(C) Individual health insurance plans and commercial health insurance plans doing business in Arkansas and in surrounding states.

(3) The methodology of the independent annual Medicaid provider rate review and the selection of other state Medicaid programs used for comparison shall be determined by the department.

(c)(1)(A) On or before September 1, 2016, the department, with approval from the Governor, shall submit an implementation plan for this section to the Arkansas Health Reform Legislative Task Force.

(B) The implementation plan shall include without limitation:

(i) A draft of the scope of work;

(ii) The requirements listed in subsection (a) of this section and subdivision (b)(2) of this section;

(iii) The actual Medicaid provider rates to be compared as described in subdivision (b)(2) of this section;

(iv) An estimation or range of costs associated with this section; and

(v) A plan to include Medicaid provider input in the design of the annual Medicaid provider rate review.

(2) The department, with approval from the Governor, shall report annually the results of the independent annual Medicaid provider rate review to the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor.

20-77-2713. Administration of the global waiver.

(a) The Department of Human Services shall:

(1) Apply for:

(A) A global waiver for the Arkansas Medicaid Program as a whole;

(B) Any other federal waivers necessary to implement this subchapter; and

(C) Any Medicaid state plan amendments necessary to implement this subchapter;

(2) Adopt rules necessary to implement the provisions of the federal waivers or Medicaid state plan amendments, or both; and

(3) Revoke all Medicaid state plan amendments or federal waivers that duplicate services, terms, or eligible individuals provided for in the global waiver.

(b)(1) The Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor shall oversee the global waiver application process.

(2) Ten (10) days before the submission of the global waiver application to the Centers for Medicare and Medicaid Services, the department shall provide the proposed submission data concerning the global waiver application to the Legislative Council meeting in conjunction with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on

Public Health, Welfare, and Labor.

(3)(A) Before the final acceptance of the global waiver by the state, the Legislative Council meeting in conjunction with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor shall review all materials concerning the global waiver, including without limitation the materials submitted by the state and the tentative approval letter issued by the Centers for Medicare and Medicaid Services.

(B) The department may accept the tentative approval letter after the review of the Legislative Council meeting in conjunction with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor unless the authority to accept the approval is repealed.

(4) If additional legislation is needed to implement the global waiver, the department shall submit to the Governor, the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor proposed statutory changes or proposed legislative language.

20-77-2714. Provisional rates of nursing homes.

The Department of Human Services shall prohibit provisional reimbursement rates for nursing facilities that have previously received provisional reimbursement rates on the same nursing facility within seven (7) years and six (6) months.

20-77-2715. Long-term care and developmental disabilities.

(a) The Department of Human Services shall seek amendments to all federal waivers or through a global waiver as described in § 20-77-2713 that serve individuals who have long-term care needs and individuals with developmental disabilities to include:

(1)(A) An independent assessment.

(B) The independent assessment under the federal waiver for individuals with long-term care needs shall be the most current InterRai.

(C) The independent assessment under the federal waiver for individuals with developmental disabilities shall be:

(i) The Supports Intensity Scale-Adults Version™ for

individuals seventeen (17) years of age and older; and

(ii) The Supports Intensity Scale-Children's Version™ for individuals between five (5) and sixteen (16) years of age.

(D) The department may adopt by rule an independent assessment instrument for individuals five (5) years of age or younger.

(E) The department may by rule:

(i) Modify the independent assessment instruments identified in subdivision (a)(1) of this section; or

(ii) Select a different independent assessment instrument;

(2) The allocation of services for home- and community-based services and supports, hours of service for home- and community-based services and supports, and costs for home- and community-based services and supports, based on the assessed need and level of acuity;

(3) Person-centered planning;

(4) An assessment of individual strengths and natural supports;

(5) Independent case management; and

(6) Assurance of dignity for the patient.

(b)(1) The federal waiver for individuals with long-term care needs shall cover eligible individuals who are:

(A) Between twenty-one (21) and sixty-four (64) years of age who have physical disabilities; and

(B) Over sixty-five (65) years of age.

(2) The federal waiver for individuals with developmental disabilities shall cover eligible individuals with developmental disabilities without regard to age.

(c)(1) Eligibility under the federal waivers shall be based on the acuity level determined by the independent assessment as well as on individual safety and risk factors.

(2) The acuity level shall be established as follows:

(A) Acuity Level 1 refers to the level of nursing care required for individuals who are currently residing in a nursing facility, a human development center within the state, or an intermediate care facility;

(B) Acuity Level 2 refers to the level of nursing care required for individuals who meet the criteria for either a nursing facility or an intermediate care facility for developmental disabilities but who

choose instead to receive home- and community-based services and supports; and

(C) Acuity Level 3 refers to the level of nursing care required for individuals who do not meet the criteria for either a nursing facility or an intermediate care facility for developmental disabilities, but who need a moderate amount of home- and community-based services to delay or prevent the immediate need for institutional care, as determined by the department.

(3)(A) The average cost per person within an intermediate care facility for developmental disabilities shall be the cost cap on home- and community-based services.

(B) The department shall establish a cost cap for individuals in Acuity Level 3 by rule, upon consultation and review by the Arkansas Health Reform Legislative Task Force.

(d) The department shall:

(1) Develop and implement supportive employment programs for individuals with developmental disabilities; and

(2) In coordination with the Office of Medicaid Inspector General, analyze and streamline billing codes related to developmental disability services.

(e)(1) The department shall take into consideration, at the time of the independent assessment and the development of the plan of care, any additional services an eligible individual may be receiving to avoid duplication of service.

(2) The department shall strengthen and define program eligibility within the Medicaid state plan to ensure that eligibility for services under the state plan is based on defined criteria and that all approved services under the state plan meet the medical needs of the eligible individual so that additional waiver services are unnecessary.

20-77-2716. Behavioral health and mental health services.

(a)(1) The Department of Human Services shall convert the existing behavioral health and mental health system to an evidence-based and best-practice system designed to address the needs of:

(A) Adults with serious and persistent mental illnesses as determined by the department in conjunction with the administrative services

organization; and

(B) Children and adolescents with serious emotional disturbances and related disorders as determined by the department in conjunction with the administrative services organization.

(2) The department may apply for any necessary federal waivers or state plan amendments to implement this section.

(b)(1) The new evidence-based and best-practice system for adults shall include without limitation:

(A) Psychiatric emergency services;

(B) Brief intervention services;

(C) Illness management and recovery;

(D) Assertive community treatments for urban and rural areas;

(E) Day supportive services;

(F) Integrated dual disorders treatments;

(G) Identified cognitive behavioral therapies; and

(H) Dialectical behavioral therapy.

(2) The new evidence-based and best-practice system for children and adolescents shall include without limitation:

(A) Cognitive behavioral therapies for specified disorders;

(B) Multisystemic individual therapy and family therapy;

(C) Trauma-informed therapy;

(D) Group therapy for specified disorders; and

(E) Services for children and adolescents in foster care.

(3) The department shall develop a schedule of psychiatric diagnostic conditions to be covered.

(4) The department shall develop and implement the following reforms regardless of the age of the Medicaid beneficiary:

(A) Require that a Medicaid beneficiary have a diagnosis of a mental illness and a referral before receiving behavioral health services;

(B) Apply a tiered approach based on diagnosis and level of acuity;

(C) Incorporate school-based services into the tiered referral system to ensure care coordination;

(D) In coordination with the administrative services organization, analyze and streamline maximum allowable unit charges, group therapy duration times, and frequency of treatment plan renewals as they relate to behavioral health services; and

(E) Weekly or daily caps on the number of units of behavioral care services that a Medicaid beneficiary can receive.

(c) The department may contract with one (1) or more independent entities for the new evidence-based and best-practice system, psychiatric inpatient care, and residential treatment centers to provide:

(1) Eligibility determinations;

(2) Plans of care for a Medicaid beneficiary;

(3) Prior authorizations;

(4) Utilization reviews; and

(5)(A) Independent assessments for all behavioral health services to determine eligibility and type, number, scope, and duration of services needed.

(B) The independent assessments used shall be:

(i) The Level of Care Utilization System Assessment Instrument for individuals who are eighteen (18) years of age or older; and

(ii) The Child and Adolescent Needs and Strengths Assessment Instrument for individuals who are between six (6) and seventeen (17) years of age.

(C) The department may by rule:

(i) Modify the independent assessment instruments identified in subdivision (c)(5)(B) of this section;

(ii) Select a different independent assessment instrument; or

(iii) Permit a participating provider to provide emergency services to an adult or child in the absence of an independent assessment.

(d) School-based services for children and adolescents shall not be provided on the same day when school campus services are provided, except in:

(1) Emergency situations when risk to the child or to others is present; or

(2) When prior authorization has been approved.

(e) Thirty (30) days before the submission of a federal waiver or a

state plan amendment, the department shall report to the Arkansas Health Reform Legislative Task Force, the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor on individual case coordination among:

(1) The existing behavioral health and mental health system providers;

(2) Psychiatric inpatient services;

(3) Residential treatment centers;

(4) The Arkansas State Hospital; and

(5) The Division of Children and Family Services of the Department of Human Services.

20-77-2717. Child health management services and developmental day treatment clinic services.

(a)(1) The Department of Human Services shall develop, in collaboration with providers, a comprehensive plan to improve:

(A) The identification of eligible infants, children, and adolescents for inclusion in the Arkansas Medicaid Program;

(B) The accuracy of the assessment of need and appropriate level of services; and

(C) The cost-effective delivery of necessary services that measure medical outcomes and developmental outcomes.

(2) The department may apply for any necessary federal waivers or state plan amendments to implement this section.

(b) The comprehensive plan shall include without limitation:

(1) Universal child independent standardized assessment by primary care physicians directly or in coordination with another healthcare provider during early and periodic screening, diagnostic, and treatment visits;

(2) Clearly defined eligibility standards for habilitation, speech, physical, and occupational therapies that augment the determination process for medical necessity;

(3) Clearly defined developmental outcomes for all child health management services and developmental day treatment clinic services to be included in an annual treatment plan review and a biannual treatment plan review to indicate the need for continued, adjusted, or reduced benefits for

each infant, child, or adolescent receiving services under the program;

(4) Cleary defined procedures for prior authorization for all child health management services and developmental day treatment clinic services;

(5) Utilization review of all child health management services and developmental day treatment clinic services;

(6) Services provided based on timelines within the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq., as it existed on January 1, 2016;

(7)(A) A weekly cap on speech, physical, and occupational service units to be established at one hundred twenty (120) minutes for individuals under six (6) years of age and ninety (90) minutes for individuals between six (6) and twenty (20) years of age.

(B) Prior authorization by an independent physician is required for services that exceed the weekly cap;

(8) A weekly cap on developmental day treatment clinic service hours, child health management service hours, and habilitation service hours based on a medically based independent assessment process involving a physician prescribing the type, number, scope, and duration of the services; and

(9) Alignment of the weekly caps described in subdivisions (b)(7) and (8) of this section and prior authorization for services that exceed the weekly caps across child health management services, developmental day treatment clinical services, independent Medicaid providers, and school-based health services.

20-77-2718. Provider reimbursement withholdings — Provider Withholding Account.

(a)(1)(A) The Department of Human Services shall withhold two percent (2%) of provider reimbursement to a developmental disability services provider, a behavioral health services provider, and a child health management services provider.

(B) Subdivision (a)(1)(A) of this section does not apply to human development centers operating in this state.

(2) A Medicaid provider offering developmental disability services and behavioral health services is not exempt from this section.

(3) The provider reimbursement withholdings shall be cost shared with Medicaid providers who are determined by the department to have the best outcomes in patient health.

(4) The amount of the cost-sharing payments shall be determined by the department based solely on the best outcomes in patient health.

(b)(1) There is created within the Arkansas Medicaid Program Trust Fund a designated account known as the "Provider Withholding Account".

(2) The provider reimbursement withholdings described in subsection (a) of this section shall be deposited into the Provider Withholding Account.

(3) The Provider Withholding Account shall be separate and distinct from the General Revenue Fund Account of the State Apportionment Fund and shall be supplementary to the Arkansas Medicaid Program Trust Fund.

(4) Moneys in the Provider Withholding Account shall not be used to replace other general revenues appropriated and funded by the General Assembly or other revenues used to support Medicaid.

(5) The Provider Withholding Account shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues.

(6)(A) The moneys in the Provider Withholding Account shall be used only as follows:

(i) To make cost-sharing payments under subsection (a) of this section;

(ii) To reimburse moneys collected by the department from providers through error or mistake or under this subchapter; or

(iii) To obtain matching federal funds for developmental disability services and behavioral health services.

(B)(i) The Provider Withholding Account shall retain account balances remaining each fiscal year.

(ii) At the end of each fiscal year, any positive balance remaining in the Provider Withholding Account shall be factored into the calculation of the cost sharing.

(C) A provider shall not be guaranteed that its cost-sharing payments will equal or exceed the amount of its provider reimbursement withholding.

20-77-2719. Limitations on multiple provider numbers.

(a) The Department of Human Services shall develop a plan to curb a Medicaid provider from rotating billable days for a Medicaid beneficiary between various Medicaid provider numbers and various Medicaid provider types.

(b) If the department does not address the issue described in subsection (a) of this section within five (5) days of the effective date of this section, a healthcare organization or a healthcare provider shall be prohibited from obtaining more than two (2) Medicaid provider numbers and from being a Medicaid provider for more than two (2) categories.

20-77-2720. Savings within long-term care.

(a)(1) Within thirty (30) days of the effective date of this section, the Department of Human Service shall enter into and finalize a memorandum of understanding with a long-term care services and supports provider group lead by the Arkansas Health Care Association to provide healthcare coverage for individuals who require long-term care services and supports and who are:

(A) Sixty-five (65) years of age or older;

(B) Blind; or

(C) Disabled.

(2) The memorandum of understanding shall include:

(A) Steps to implement the specific proposals to reform the payment and implementation of long-term care services and supports, including without limitation the assessment to determine level of acuity and patient needs and the tiered care delivery structure contained in the proposal by the Arkansas Health Care Association to the Arkansas Health Reform Legislative Task Force on February 17, 2016; and

(B) Information detailing the savings to be generated to the State of Arkansas under the memorandum of understanding, including without limitation:

(i) At least fifty million dollars ($50,000,000) each year for at least two (2) years as defined by the memorandum of understanding; and

(ii) Aggregate savings of not less than two hundred fifty million dollars ($250,000,000) by through fiscal year 2021.

(b) The department shall report to the Legislative Council any federal

waiver amendments, state plan amendments, or administrative rule changes necessary for the implementation of the memorandum of understanding described in subsection (a) of this section.

(c) An independent actuary shall be responsible for verifying the savings.

(d) If the savings identified in subdivision (a)(2)(B)(i) of this section are not achieved and the department has met its responsibilities outlined in the memorandum of understanding, the department, only after receiving written direction from the Governor, shall enter into a contract with a managed care organization for the population described in subdivision (a)(1) of this section.

(e) If the department and long-term care services and supports provider group lead by the Arkansas Health Care Association are unable to reach an agreement related to the terms of the memorandum of understanding, the department shall:

(1) Seek federal waiver amendments, state plan amendments, administrative rule changes, or other authority necessary for the implementation of the reforms contained within the proposal by the Arkansas Health Care Association to the Arkansas Health Reform Legislative Task Force on February 17, 2016;

(2) Ensure that an independent actuary is responsible for verifying the savings; and

(3) Require that the reforms generate aggregate savings of not less than two hundred fifty million dollars ($250,000,000) by through fiscal year 2021.

20-77-2721. Duties of Legislative Council meeting in conjunction with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor.

(a) The Legislative Council meeting in conjunction with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor shall:

(1) Review whether expenditures of the Arkansas Medicaid Program are appropriate to accomplish state objectives for health care;

(2) Review and approve proposed rules regarding the program;

(3)(A) Review proposed contracts for twenty-five thousand

dollars ($25,000) or more before the execution of the contracts.

(B) The Department of Human Services shall provide a list of all contracts for less than twenty-five thousand dollars ($25,000) to the Legislative Council on a monthly basis;

(4) Oversee the development and implementation of the reform model of the program and this subchapter, including all recommendations approved by the Arkansas Health Reform Legislative Task Force;

(5) Review reports filed with the Legislative Council, including without limitation reports filed under §§ 20-77-111, 20-77-1001, 20-77-2206, and 20-77-2509;

(6) Review ongoing data collection, research, and evaluation of the program;

(7) Review and recommend policies and changes for the program; and

(8) Study other Medicaid-related and healthcare matters as the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor deem necessary.

(b)(1) Annually by December 15, the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor shall provide to the General Assembly:

(A) Any analysis or findings resulting from activities under this section that the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor deem relevant; and

(B) Recommendations for any changes to the program.

(2) The Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor may make interim reports to the General Assembly regarding the expenditures of the program.

(c)(1) During a regular, fiscal, or extraordinary session of the General Assembly, the Joint Budget Committee shall perform the functions assigned to the Legislative Council meeting in conjunction with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor under this subchapter.

(2) This subsection does not limit the authority of the

Legislative Council meeting in conjunction with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor to meet during a recess as authorized by § 10-2-223 or § 10-3-211.

(d) The Legislative Council and the Joint Budget Committee may:

(1) Establish or utilize one (1) or more subcommittees to assist in their duties under this subchapter;

(2) Assign information filed with the Legislative Council under this subchapter to one (1) or more subcommittees of the Legislative Council, including without limitation a subcommittee created under subdivision (d)(1) of this section; and

(3) Delegate their duties under this subchapter to one (1) or more subcommittees of the Legislative Council, subject to the final approval of the Legislative Council or the Joint Budget Committee.

20-77-2722. Rule-making authority.

(a) The Department of Human Services shall:

(1) Promulgate rules to implement this subchapter; and

(2) Seek all appropriate federal waivers and state plan amendments necessary to implement this subchapter.

(b) This subchapter does not preclude:

(1) The department from seeking to combine, renew, or replace the federal waivers referenced within this subchapter if the terms of the combined, renewed, or replacement waiver satisfies the remaining requirements of this subchapter;

(2) The department from seeking new federal waivers to:

(A) Serve individuals not currently receiving services under an existing federal waiver; or

(B) Provide services not currently provided under an existing waiver; or

(3) The authority of the department to contract with a managed care organization for dental services to serve Medicaid beneficiaries through a comprehensive risk contract.

SECTION 2. Arkansas Code Title 19, Chapter 5, Subchapter 11, is amended to add an additional section to read as follows:

19-5-1146. Community Living and Employment Supports Trust Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "Community Living and Employment Supports Trust Fund".

(b) The fund shall consist of:

(1) Premium tax collections transferred to the fund under § 26-57-610(b)(4)(B);

(2) Dental managed care cost savings; and

(3) Other revenues and funds authorized by law.

(c) The fund shall be used by the Department of Human Services to:

(1) Provide medical assistance for individuals with developmental disabilities;

(2) Enable and enhance community living for individuals with developmental disabilities;

(3) Encourage and expand employment supports for individuals with developmental disabilities;

(4) Provide for assessments for qualified individuals with developmental disabilities and a capped amount based upon the assessment to each individual as determined by the Department of Human Services; and

(5) Accomplish other purposes at the direction of the Director of the Department of Human Services.

SECTION 3. 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 managed care organization under § 20-77-2706.

SECTION 4. 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:

(4)(A) The taxes based on premiums collected under the Arkansas Medicaid Program as administered by a managed care organization under § 20-

77-2706 shall be, at the time of deposit, separately certified by the commissioner to the Treasurer of State and the Chief Fiscal Officer of the State for classification and distribution under this section.

(B)(i) From time to time, the Chief Fiscal Officer of the State shall transfer on his or her books and those of the State Treasurer and the Auditor of the State each fiscal year up to fifteen million dollars ($15,000,000) or so much as is made available of the taxes based on premiums collected under the program as administered by a managed care organization under § 20-77-2706 to the Community Living and Employment Supports Trust Fund.

(ii) Upon the determination of the Chief Fiscal Officer of the State, that the annual amount to be transferred under subdivision (b)(4)(B)(i) will be less than fifteen million dollars ($15,000,000), then the Chief Fiscal Officer of the State shall transfer on his or her books and those of the State Treasurer and the Auditor of the State general revenue in the Department of Human Services – Division of Medical Services paying account in an amount necessary to insure a total annual transfer of fifteen million dollars ($15,000,000) authorized in this section and in subdivision (b)(4)(B)(i) of this section to the Community Living and Employment Supports Trust Fund.

(iii) Any portion of the taxes based on premiums collected under the Arkansas Medicaid Program as administered by a dental managed care organization that are not transferred under subdivision (b)(4)(B)(i) of this section shall be deposited into the Community Living and Employment Supports Trust Fund.

(C) Subdivision (b)(4) of this section shall be effective on and after July 1, 2018.

SECTION 5. DO NOT CODIFY. Primary care providers – Pharmacy – Healthcare reforms.

(a) The following reforms are based on recommendations to the Arkansas Health Reform Legislative Task Force from stakeholders, the healthcare industry, and the consulting firm hired by the Arkansas Health Reform Legislative Task Force.

(b) The Department of Human Services shall make the following reforms to primary care in the Arkansas Medicaid Program:

(1) Promote telemedicine for specialist services;

(2) Provide reimbursement for wellness exams and wellness laboratory services for the adult population on the traditional Arkansas Medicaid Program;

(3) Increase reimbursements for vaccinations;

(4) Eliminate the limitations on the number of office visits for Medicaid beneficiaries who are enrolled in patient-centered medical homes;

(5) Increase or eliminate caps on laboratory services and radiology services for Medicaid beneficiaries who are enrolled in patient-centered medical homes; and

(6) Provide limited reimbursement for office visits for diabetes self-management programs or diabetes management programs.

(c) The department shall make the following reforms to the pharmacy program in the Arkansas Medicaid Program:

(1) Expand the preferred drug list;

(2) Include behavioral health medications and antipsychotic medications on the preferred drug list;

(3) Change reviews of plans of care by a licensed psychiatrist to patients seven (7) years of age and gradually increase the age of the review to ten (10) years of age with evidence of continued cost-avoidance;

(4) Add an additional one hundred (100) medications to the Competitive Acquisition Program;

(5) Eliminate prescription drug limits on maintenance medications;

(6) Provide reimbursement for immunizations and vaccinations within certain criteria and by referrals as determined by the department;

(7) Encourage the addition or inclusion of a community pharmacist as a vital component of the Arkansas Patient-Centered Medical Home Program;

(8) Increase reimbursements for vaccinations; and

(9)(A) Explore the National Average Drug Acquisition Cost pricing model with a corresponding professional dispensing fee and the multistate prescription drug list.

(B) The department shall report to the Governor, the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, the House Committee on Public Health, Welfare, and Labor, and the

Arkansas Health Reform Legislative Task Force:

(i) Whether the National Average Drug Acquisition Cost pricing model or multistate prescription drug list, or both, is the best practice for the State of Arkansas; and

(ii) Any changes necessary to implement the National Average Drug Acquisition Cost pricing model or multistate prescription drug list, or both.

(d) The department shall make the following reforms to the Arkansas Medicaid Program:

(1) Require that each Medicaid beneficiary receive a "health scorecard" to promote and encourage wellness;

(2) Provide reimbursement for physical therapy, occupational therapy, and speech therapy for adult Medicaid beneficiaries in a non-institutional setting or a non-hospital setting;

(3) Provide health and healthcare education to Medicaid beneficiaries:

(A) In a new enrollee orientation program; and

(B) Through the Healthy Arkansas Educational Program established by Acts 2015, No. 1005, § 1, with the assistance of the University of Arkansas Division of Agriculture Cooperative Extension Service; and

(4) Promote the Healthy Active Arkansas initiative created by the Governor.

SECTION 6. DO NOT CODIFY. TEMPORARY LANGUAGE. Timeline for implementation and reports.

Within ninety-five (95) days of the enactment date of this act, the Department of Human Services shall report to the Arkansas Health Reform Legislative Task Force a detailed implementation plan of Section 1 and Section 10 of this act, including without limitation:

(1) For Section 1 and Section 10 of this act:

(A) A functional project management plan;

(B) A timeline of implementation;

(C) A list of challenges and needed resources;

(D) Estimated program savings and administrative savings; and

(E) A list of barriers and solutions;

(2) A schedule, purpose, and timeline of short-term and long-term rule changes, waiver amendments, or state plan amendments needed to implement this act; and

(3) A contingency plan addressing short-term and long-term saving targets if the department is unable to implement any section of this act in a timely fashion.

SECTION 7. DO NOT CODIFY. TEMPORARY LANGUAGE. Reform to rehabilitative services for persons with mental illness.

(a) The Department of Human Services shall:

(1) Work with existing providers of rehabilitative services for persons with mental illness to develop actions and reforms that will decrease any duplication of services and unnecessary cost; and

(2) Complete the revision of the benefit for rehabilitative services for persons with mental illness before the conversion of the existing behavioral health and mental health system to an evidence-based and best-practice system and any other reform model enacted by the General Assembly.

(b) The Office of Medicaid Inspector General shall assist the department in completing the revision of the benefit for rehabilitative services for persons with mental illness.

(c) On or before October 1, 2016, the department shall report to the Arkansas Health Reform Legislative Task Force, the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor on improvement strategies to be employed.