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

By: Representative Pilkington

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.

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 covered 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 a covered 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 covered 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 covered 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; and

(7) Encourage the most efficient use of taxpayer funds.

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) Navigation of 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;

(4) "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;

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

(A) Significant behavioral health needs 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 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;

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

(7) "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 a covered Medicaid beneficiary population that affect the health of the member of a covered Medicaid beneficiary

population;

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

(9) "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 covered Medicaid beneficiary populations;

(10) "Participating provider" means an organization or individual that is a member of a risk-based provider organization and delivers healthcare services to covered Medicaid beneficiary populations;

(11) "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; and

(12) "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.

(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 a covered 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 a covered Medicaid beneficiary population receives services during the period covered by the payment.

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 covered 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) Not be reduced 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 covered 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; or

(6) Human development center services.

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:

(A) Licensed or certified direct service provider of

developmental disabilities services;

(B) Licensed or certified direct service provider of behavioral health services;

(C) Hospital or hospital services organization;

(D) Physician practice; and

(E) 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 medical, mental health, and substance abuse 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 clinic;

(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 covered Medicaid beneficiary populations.

(c) A risk-based provider organization may provide healthcare services directly to covered 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 or by state law; and

(B) Assure efficiency, economy, quality, and equal access

to covered Medicaid beneficiary populations in the same manner as for groups of 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.

(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 or by state law; and

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

(2) A direct service provider that is delivering services to the covered 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 covered Medicaid beneficiary populations into the risk-based provider organization and remove members of covered 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; and

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

(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 covered 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 minimum 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 § 26-57-603; 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 covered 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 includes risk adjustments, reinsurance, or 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 may develop rules 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 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 an annual 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 covered 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 annual 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 annual 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 covered 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 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 covered 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 covered 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 covered Medicaid beneficiary populations is resulting in excessive and unnecessary costs to the Arkansas Medicaid Program and to the State of Arkansas; that the covered Medicaid beneficiary populations are growing at a rate that is unsustainable under the current method of serving the covered Medicaid beneficiary populations; that the Medicaid provider-led organized care system will improve quality and efficiencies of healthcare services to covered 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