State of Arkansas
95th General Assembly
Regular Session, 2025

A Bill

HOUSE BILL 1818

By: Representative L. Johnson
By: Senator B. Davis

For An Act To Be Entitled

AN ACT TO CREATE THE MEDICAID PROVIDER-LED CARE TRANSPARENCY AND ACCOUNTABILITY ACT; AND FOR OTHER PURPOSES.

Subtitle

TO CREATE THE MEDICAID PROVIDER-LED CARE TRANSPARENCY AND ACCOUNTABILITY ACT.

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 30 — Medicaid Provider-Led Care Transparency and Accountability Act

20-77-3001. Title

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

20-77-3002. Workgroup for risk-based provider organization quality and effectiveness of care.

(a) The Department of Human Services shall create a workgroup comprised of representatives of Medicaid beneficiaries who are enrolled with a risk-based provider organization and providers for intellectual and developmental disabilities and behavioral health services to help develop appropriate standards for risk-based provider organizations to follow to

improve the quality and effectiveness of care.

(b) The workgroup described in this section may be a subcommittee of the Medicaid Advisory Committee.

20-77-3003. Care coordination.

(a) A risk-based provider organization shall pay a direct service provider for care coordination from the capitated rate that the Department of Human Services pays the risk-based provider organization.

(b) A risk-based provider organization may subcontract with direct service providers, with appropriate compensation, any care coordination duties assigned to the risk-based provider organization as long as the assignment does not include the federal conflict-free functions that include eligibility evaluations, assessments of functional needs, and person-centered care plan development.

(c) In consultation with the workgroup established under § 20-77-3002, a risk-based provider organization shall develop enhanced education and training for care coordinators, including behavior supports.

(d) A care coordinator of a risk-based provider organization shall ensure that meetings for development of person-centered service plans align with provider care plan renewal dates except when unavoidable.

20-77-3004. Gag clause prohibited.

(a) A risk-based provider organization or affiliated entity shall not prohibit a direct service provider who is an investor in the risk-based provider organization or an affiliated entity from taking positions or advocating publicly on agency rules, legislation, or other matters of public interest that conflict with the position or interests of the risk-based provider organization.

(b) If a contract between a risk-based provider organization and a direct service provider contains a provision that conflicts with subsection (a) of this section, the provision of the contract is void.

20-77-3005. Quality initiatives.

(a) The Department of Human Services shall require a contracted external quality review organization to collect data with specific quality metrics for risk-based provider organizations aimed at improving services for

individuals with intellectual and developmental disabilities, including appropriate measures from the Home- and Community-Based Services Quality Measure Set.

(b) The contracted external quality review organization shall consult with the workgroup established under § 20-77-3002.

(c)(1) For individuals diagnosed with an intellectual or developmental disability, the department shall require a risk-based provider organizations to initiates services through an intellectual or developmental disability services provider within sixty (60) days of the individual's assignment to a risk-based provider organization.

(2) If the risk-based provider organization does not comply with subdivision (c)(1) of this section, the department shall impose penalties upon the risk-based provider organization.

(d)(1) The department shall authorize the use of assistive and enabling technology, including smart home technology, as a recognized service delivery method for home- and community-based services.

(2) The authorization under subdivision (d)(1) of this section shall extend to the provision of services through remote staffing models where appropriate and in accordance with applicable rules.

(e) In consultation with the workgroup, the department shall establish:

(1) Value-based payment initiatives for intellectual and developmental disabilities and behavioral health providers who meet quality of care targets;

(2) New evidence-based treatment services to aid high-utilizing members assessed with behavioral health needs to access appropriate care; and

(3) A non-medical transportation billing code or modifier for use under supported employment categories separate from transportation under supported living categories.

(f) In recognition of the higher intensity of services required by individuals with complex conditions in the Community Support System Provider Program, a risk-based provider organization shall determine appropriate direct service provider rates for services required by individuals with complex conditions in the Community Support System Provider Program rather than defaulting to supported living category rates.

20-77-3006. Credentialing.

(a) The Department of Human Services shall require the risk-based provider organizations to standardize credentialing across all risk-based provider organizations.

(b)(1) A risk-based provider organization shall obtain credentialing information on therapists, including speech-language therapists, physical therapists, occupational therapists, and board-certified behavior analysists, through the Medicaid portal where providers enter credentialing information.

(2) If additional information is required, a risk-based provider organization shall use the Council for Affordable Quality Healthcare National Database to obtain the additional information.

20-77-3007. Audit fairness.

(a) The Department of Human Services, risk-based provider organizations, and contracted entities conducting audits of providers shall establish secure online portals for providers to submit information and may not make duplicate requests.

(b) Until the portal is established or if the portal is down, a risk-based provider organization shall cover the provider's reasonable costs of copying records at no less than twenty cents ($0.20) per page, plus postage and shipping costs.

(c) A risk-based provider organization shall:

(1) Make no more than two (2) audit requests per calendar year from a direct service provider unless a complaint has been lodged or there is reasonable suspicion of fraud or abuse;

(2) Allow a provider at least sixty (60) days to supply records requested by the risk-based provider organization, except in an emergency; and

(3) Allow a provider at least sixty (60) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit.

(d) The period covered by an audit shall not exceed twelve (12) months from the date the claim was submitted to a risk-based provider organization.

(e) The Medicaid Fairness Act, § 20-77-1701 et seq., shall continue to apply to the risk-based provider organizations.

20-77-3008. Transparency and reporting.

(a)(1)(A) Annually on or before March 1, a risk-based provider organization shall file with the Department of Human Services a full and true statement of the financial condition, transactions, and affairs of the risk-based provider organization as of December 31 of the preceding year.

(B) The department may grant an extension of time to file the statement required under subdivision (a)(1)(A) of this section for good cause if a written application for an extension of time is received at least five (5) business days before the filing due date.

(2) The statement required under subdivision (a)(1)(A) of this section shall:

(A) Be prepared according to the companion National Association of Insurance Commissioners' Annual and Quarterly Statement Instructions and follow those accounting principles and procedures prescribed by the companion National Association of Insurance Commissioners' Accounting Practices and Procedures Manual; and

(B) Include the following information of the risk-based provider organization:

(A) Total assets;

(B) Total liabilities;

(C) Total reserves;

(D) Net premium income;

(E) Total claims paid;

(F) Total claims denied;

(G) Payments to or from the state under a risk corridor;

(H) The amount paid by the Arkansas Medicaid Program to the risk-based provider organization for the previous period of January 1 through December 31;

(I) The amount that the risk-based provider organization paid to in-network providers from the previous period of January 1 through December 31;

(J) The amount that the risk-based provider organization paid to out-of-network providers from the previous period of January 1 through December 31;

(K) A list of any underwriting, auditing, actuarial,

financial analysis, treasury, and investment expenses;

(L) A list of any marketing and sales expenses, including without limitation advertising, member relations, member enrollment, and all expenses associated with producers, brokers, and benefit consultants;

(M) A list of any claims operations expenses, including without limitation expenses for adjudication, appeals, settlements, and expenses associated with paying claims;

(N) A list of any medical administration expenses, including without limitation disease management, utilization review, and medical management;

(O) A list of any network operations expenses, including without limitation expenses for contracting, hospital and physician relations, and medical policy procedures;

(P) A list of any charitable expenses, including without limitation contributions to tax-exempt foundations and community benefits;

(Q) The amount of state insurance premium taxes paid;

(R) The fees related to depreciation;

(S) A list of miscellaneous expenses described in detail by expense, including any expense not previously included in this section; and

(T) Any other information required by the department.

(b) A risk-based provider organizations shall file an executive summary of the statement required under subdivision (a)(1)(A) of this section with:

(1) The House Committee on Public Health, Welfare, and Labor; and

(2) The Senate Committee on Public Health, Welfare, and Labor.

(c) Annually, between thirty (30) and sixty (60) days before the initial date of open enrollment in a risk-based provider organization, a risk-based provider organization shall prominently display on its website the report required under subdivision (a)(1)(A) of this section and the executive summary of the report required under subdivision (b) of this section.

20-77-3009. Legislative oversight.

(a) Before submitting the quarterly reports required under § 20-77-2707 to the Legislative Council, the Department of Human Services shall submit the quarterly reports required under § 20-77-2707 for review to:

(1) The Senate Committee on Public Health, Welfare, and Labor; and

(2) The House Committee on Public Health, Welfare, and Labor.

(b) The Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor shall jointly provide ongoing oversight of the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq.

(c)(1) The department shall commission an annual actuarial report concerning rate setting for risk-based provider organizations that addresses the projected costs and necessary rates for direct service providers as part of the capitated rate development to the same extent as the annual actuarial report addresses costs and other allowances for the risk-based provider organizations.

(2) The Legislative Council, or the Joint Budget Committee if the General Assembly is in session, shall favorably review the annual actuarial report under subdivision (c)(1) of this section before submission to the Centers for Medicare & Medicaid Services.

20-77-3010. Private right of action.

An enrollee or direct service provider may file suit for equitable relief against the Department of Human Services or a risk-based provider organization in a court of competent jurisdiction and is entitled to collect reasonable attorneys' fees and costs.

20-77-3010. Rules.

The Department of Human Services may promulgate rules to implement this subchapter.

SECTION 2. DO NOT CODIFY. SEVERABILITY CLAUSE. If any provision of this act or the application of this act to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of

this act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are declared severable.

SECTION 3. DO NOT CODIFY. TEMPORARY LANGUAGE. Implementation of this act.

(a) The requirements in § 20-77-3004(a) shall begin on January 1, 2026.

(b) Within sixty (60) days of the effective date of this subchapter, the department shall submit all required applications, amendments, and supporting documentation to the Centers for Medicare & Medicaid Services for approval to ensure compliance with federal requirements and facilitate the implementation of these service delivery methods, including without limitation:

(1) An amendment to the state Medicaid plan; and

(2) Any necessary modifications to existing waiver programs.

(c) The initial standardization of credentialing under § 20-77-3007(a) shall occur within three (3) months of the effective date of this act.