Stricken language would be deleted from and underlined language would be added to present law.
Act 775 of the Regular Session

1 State of Arkansas *As Engrossed: H3/2/17 H3/10/17 S3/20/17*
2 91st General Assembly A Bill
3 Regular Session, 2017 HOUSE BILL 1706
4
5 By: Representatives Pilkington, Davis, Collins, Brown, G. Hodges
6 *By: Senator J. Cooper*
7
8 **For An Act To Be Entitled**
9 AN ACT TO CREATE THE MEDICAID PROVIDER-LED ORGANIZED
10 CARE ACT; TO REFORM THE ARKANSAS MEDICAID PROGRAM TO
11 *IMPROVE PATIENT OUTCOMES; TO DESIGNATE THAT A RISK-*
12 *BASED PROVIDER ORGANIZATION IS AN INSURANCE COMPANY*
13 *FOR CERTAIN PURPOSES UNDER ARKANSAS LAW; TO ELIMINATE*
14 *THE WAITING LIST FOR THE ALTERNATIVE COMMUNITY*
15 *SERVICES WAIVER PROGRAM; TO DECLARE AN EMERGENCY; AND*
16 FOR OTHER PURPOSES.
17
18
19 **Subtitle**
20 *TO CREATE THE MEDICAID PROVIDER-LED*
21 *ORGANIZED CARE ACT; TO DESIGNATE THAT A*
22 *RISK-BASED PROVIDER ORGANIZATION IS AN*
23 *INSURANCE COMPANY FOR CERTAIN PURPOSES*
24 *UNDER ARKANSAS LAW; AND TO DECLARE AN*
25 *EMERGENCY.*
26
27
28 *WHEREAS, it is beneficial to the State of Arkansas to be a good steward*
29 *of public money for sustainable programs for the future; and*
30
31 *WHEREAS, it is beneficial to the people of the State of Arkansas to*
32 *recognize the inherent value and contribution of individuals with*
33 *disabilities; and*
34
35 *WHEREAS, it is the policy of the State of Arkansas to:*
36 *(1) Respect the rights and privileges conveyed by federal and*

state law to beneficiaries who are individuals with disabilities;

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

(3) Allow an individual with disabilities to:

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

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

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

NOW THEREFORE,

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

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

Subchapter 27 — Medicaid Provider-Led Organized Care Act

20-77-2701. Title.

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

20-77-2702. Legislative intent and purpose.

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

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

1 services for a member of *an enrollable* Medicaid beneficiary population in
2 return for payment.
3 (c) It is the intent of the General Assembly that the Medicaid
4 provider-led organized care system created by the department shall:
5 (1) Improve the experience of health care, including without
6 limitation quality of care, access to care, and reliability of care, for
7 *enrollable* Medicaid beneficiary populations;
8 (2) Enhance the performance of the broader healthcare system
9 leading to improved overall population health;
10 (3) Slow or reverse spending growth for *enrollable* Medicaid
11 beneficiary populations and for covered services while maintaining quality of
12 care and access to care;
13 (4) Further the objectives of Arkansas payment reforms and the
14 state's ongoing commitment to innovation;
15 (5) Discourage excessive use of services;
16 *(6) Reduce waste, fraud, and abuse;*
17 *(7) Encourage the most efficient use of taxpayer funds; and*
18 *(8) Operate under federal guidelines for patient rights.*
19
20 20-77-2703. Definitions.
21 As used in this subchapter:
22 (1) "Associated participant" means an organization or individual
23 that is a member or contractor of a risk-based provider organization and
24 provides necessary administrative functions, including without limitation
25 claims processing, data collection, and outcome reporting;
26 (2) "Capitated" means an actuarially sound healthcare payment
27 that is based on a payment per person that covers the total risk for
28 providing healthcare services as provided in this subchapter for a person;
29 (3)(A) "Care coordination" means the coordination of healthcare
30 services delivered by healthcare provider teams to empower patients in their
31 health care and to improve the efficiency and effectiveness of the healthcare
32 sector.
33 (B) "Care coordination" includes without limitation:
34 (i) Health education and coaching;
35 (ii) *Promotion of links with* medical home services
36 and the healthcare system in general;

1 (iii) Coordination with other healthcare providers
2 for diagnostics, ambulatory care, and hospital services;
3 (iv) Assistance with social determinants of health,
4 *such as access to healthy food and exercise; and*
5 *(v) Promotion of activities focused on the health of*
6 *a patient and the community, including without limitation outreach, quality*
7 *improvement, and patient panel management; and*
8 *(vii) Community-based management of medication*
9 *therapy;*
10 *(4) "Carrier" means an organization that is:*
11 *(A) Licensed or otherwise authorized to transact health*
12 *insurance as an insurance company under § 23-62-103;*
13 *(B) Authorized to provide healthcare plans under § 23-76-*
14 *108 as a health maintenance organization; or*
15 *(C) Authorized to issue hospital service or medical*
16 *service plans as a hospital medical service corporation under § 23-75-108;*
17 *(5)(A) "Covered Medicaid beneficiary population" means a group*
18 *of individuals with:*
19 *(i) Significant behavioral health needs, including*
20 *substance abuse treatment and services, and who are eligible for*
21 *participation in the Medicaid provider-led organized care system as*
22 *determined by an independent assessment under criteria established by the*
23 *Department of Human Services; or*
24 *(ii) Intellectual or developmental disabilities and*
25 *who are eligible for participation in the Medicaid provider-led organized*
26 *care system as determined by an independent assessment under criteria*
27 *established by the department.*
28 *(B) "Covered Medicaid beneficiary population" does not*
29 *include individuals enrolled in a long-term care services and supports*
30 *program under 42 U.S.C. § 1396n or 42 U.S.C. § 1315, due to a physical*
31 *functional limitation;*
32 (6) "Direct service provider" means an organization or
33 individual that delivers healthcare services to *enrollable* Medicaid
34 beneficiary *population;*
35 *(7) "Enrollable Medicaid beneficiary population" means a group*
36 *of individuals who are either:*

1 *(A) Members of a covered Medicaid beneficiary population;*
2 *or*
3 *(B) Members of a voluntary Medicaid beneficiary*
4 *population;*
5 *(8)* "Flexible services" means alternative services that are not
6 included in the state plan or waiver of the Arkansas Medicaid Program and
7 that are appropriate and cost-effective services that improve the health or
8 social determinants of a member of *an enrollable* Medicaid beneficiary
9 population that affect the health of the member of *an enrollable* Medicaid
10 beneficiary population;
11 *(9)* "Global payment" means a population-based payment
12 methodology that *is actuarially sound and based* on an all-inclusive per-
13 person-per-month calculation for all benefits, administration, care
14 management, and care coordination for *enrollable* Medicaid beneficiary
15 populations;
16 *(10)* "Medicaid" means the programs authorized under Title XIX of
17 the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XXI of the
18 Social Security Act, 42 U.S.C. § 1397aa et seq., as they existed on January
19 1, 2017, for the provision of healthcare services to members of *enrollable*
20 Medicaid beneficiary populations;
21 *(11)* "Participating provider" means an organization or
22 individual that is *a member of or has an ownership interest in* a risk-based
23 provider organization and delivers healthcare services to *enrollable* Medicaid
24 beneficiary populations;
25 *(12)* "Quality incentive pool" means a funding source established
26 and maintained by the department to be used to reward risk-based provider
27 organizations that meet or exceed specific performance and outcome measures;
28 *(13)* "Risk-based provider organization" means an entity that:
29 (A)(i) Is licensed by the Insurance Commissioner under the
30 rules established for risk-based provider organizations by the commissioner.
31 (ii) Notwithstanding any other provision of law, a
32 risk-based provider organization is an insurance company upon licensure by
33 *the commissioner, but is not deemed an insurer for purposes of the Arkansas*
34 *Life and Health Insurance Guaranty Association Act, § 23-96-101 et seq.*
35 (iii) The commissioner shall not license a risk-
36 based provider organization except as provided in this subchapter;

1 (B) Is obligated to assume the financial risk for the
2 delivery of specifically defined healthcare services to *an enrollable*
3 Medicaid beneficiary population; and
4 (C) Is paid by the department on a capitated basis with a
5 global payment made, whether or not a particular member of *an enrollable*
6 Medicaid beneficiary population receives services during the period covered
7 by the *payment; and*
8 *(14) "Voluntary Medicaid beneficiary population" means a group*
9 *of individuals who:*
10 *(A) Are in need of behavioral health services or*
11 *developmental disabilities services;*
12 *(B) Are eligible for the Arkansas Medicaid Program; and*
13 *(C) May elect to enroll in a risk-based provider*
14 *organization if the group is not otherwise excluded by this subchapter.*
15
16 20-77-2704. Licensure by Insurance Commissioner.
17 (a) The Insurance Commissioner may license for participation in the
18 Medicaid provider-led organized care system one (1) or more risk-based
19 provider organizations that satisfactorily meet licensure requirements and
20 are capable of coordinating the delivery and payment of healthcare services
21 for the *enrollable* Medicaid beneficiary populations.
22 (b) The commissioner shall require a risk-based provider organization
23 to enroll members of covered Medicaid beneficiary populations statewide.
24
25 20-77-2705. Excluded services.
26 (a) Except as provided in subsection (b) of this section, all
27 healthcare services delivered through the Medicaid provider-led organized
28 care system shall:
29 (1) Be available for all members of covered Medicaid beneficiary
30 populations; and
31 (2) *Be comparable* in amount, duration, or scope as compared to
32 other Medicaid-eligible individuals as specified in the state plan for
33 medical assistance.
34 (b) The Medicaid provider-led organized care system shall be
35 implemented to the extent possible, but shall not include the following
36 services when provided to *enrollable* Medicaid beneficiary populations:

1 (1) Nonemergency medical transportation in a capitated program;
2 (2) Dental benefits in a capitated program;
3 (3) School-based services provided by school employees;
4 (4) Skilled nursing facility services;
5 *(5) Assisted living facility services;*
6 *(6) Human development center services; or*
7 *(7) Waiver services provided to adults with physical*
8 *disabilities through the ARChoices in Homecare program or the Arkansas*
9 *Independent Choices program.*
10 20-77-2706. Characteristics and duties of risk-based provider
11 organization.
12 (a) A risk-based provider organization shall:
13 (1) Be authorized to conduct business in the state;
14 (2) Hold a valid certificate of authority issued by the
15 Secretary of State;
16 (3) Have ownership interest of not less than fifty-one percent
17 (51%) by participating providers; and
18 (4) Include within membership of the risk-based provider
19 *organization:*
20 *(A) An Arkansas licensed or certified direct service*
21 *provider of developmental disabilities services;*
22 *(B) An Arkansas licensed or certified direct service*
23 *provider of behavioral health services;*
24 *(C) An Arkansas licensed hospital or hospital services*
25 *organization;*
26 *(D) An Arkansas licensed physician practice; and*
27 *(E) A pharmacist who is licensed by the Arkansas State*
28 *Board of Pharmacy.*
29 (b) A risk-based provider organization that meets the requirements of
30 subsection (a) of this section may include any of the following entities for
31 *access to and coordination with direct* service providers and to facilitate
32 access to flexible services and other community and support services:
33 (1) A carrier;
34 (2) An administrative entity;
35 (3) A federally qualified *health center;*
36 (4) A rural health clinic;

1 (5) An associated participant; or
2 (6) Any other type of direct service provider that delivers or
3 is qualified to deliver healthcare services to *enrollable* Medicaid
4 beneficiary populations.
5 (c) A risk-based provider organization may provide healthcare services
6 directly to *enrollable* Medicaid beneficiary populations or through:
7 (1) A direct service provider that is a participating provider
8 in the risk-based provider organization;
9 (2) A direct service provider subcontracted by the risk-based
10 provider organization; or
11 (3) An independent provider that enters into a provider
12 agreement or business relationship with a direct service provider.
13 (d)(1) Except as provided in subdivision (d)(2) of this section,
14 reimbursement rates paid by a risk-based provider organization to direct
15 service providers shall:
16 (A) Be determined by mutual agreement of the risk-based
17 provider organization and direct service provider without regard to Medicaid
18 *provider rates established by the Department of Human Services; and*
19 (B) Assure efficiency, economy, quality, and equal access *to*
20 *enrollable Medicaid beneficiary populations in the same manner as to*
21 *individuals who are not covered by the Arkansas Medicaid Program.*
22 (2) The reimbursement rates established by a risk-based provider
23 organization shall not be subject to any administrative review by the
24 *Insurance Commissioner.*
25 *(3) A risk-based provider organization may contract with a*
26 *Community Pharmacy Enhanced Services Network to provide enhanced pharmacist*
27 *services to manage complex patients at a mutually agreed upon rate schedule.*
28 (e)(1) Except as provided in subdivision (e)(2) of this section, all
29 policies and procedures regarding the provision of healthcare services by a
30 direct service provider shall:
31 (A) Be determined by mutual agreement of the risk-based
32 provider organization and the direct service provider without regard to
33 *Medicaid provider rates established by the Department of Human Services; and*
34 (B) Assure efficiency, economy, quality, and equal access
35 *to the enrollable Medicaid beneficiary population in the same manner as*
36 *individuals who are not covered by the Arkansas Medicaid Program*

1 (2) A direct service provider that is delivering services to the
2 *enrollable* Medicaid beneficiary populations shall:
3 (A) Meet any licensing or certification requirements set
4 by law or rule; and
5 (B) Not otherwise be disqualified from participating in
6 the Arkansas Medicaid Program or Medicare.
7 (f) Upon licensure by the commissioner, a risk-based provider
8 organization shall perform the following functions:
9 (1) Enroll members of *enrollable* Medicaid beneficiary
10 populations into the risk-based provider organization and remove members of
11 *enrollable* Medicaid beneficiary populations from the risk-based provider
12 organization;
13 (2) Ensure the following:
14 (A) Protection of beneficiary rights and due process in
15 accordance with federally mandated regulations governing Medicaid managed
16 care organizations;
17 (B) Proper credentialing of direct service providers in
18 *accordance with state and federal requirements;*
19 (C) Care coordination of members enrolled into the risk-
20 *based provider organization; and*
21 *(D) A consumer advisory council consisting of consumers of*
22 *developmental disability services and behavioral health services, including*
23 *substance abuse treatment and services;*
24 (3) Process claims or otherwise ensure payment to direct service
25 providers within time frames established under federal regulations for goods
26 and services delivered to the *enrollable* Medicaid beneficiary populations;
27 (4) Maintain the following:
28 (A) A network of direct service providers sufficient to
29 ensure that all services to recipients are adequately accessible within time
30 and distance requirements defined by the state; and
31 (B) A reserve of six million dollars ($6,000,000) and an
32 additional amount as determined by the commissioner at the initial licensure
33 based upon the risk assumed and the projected liabilities under standards
34 promulgated by rules of the State Insurance Department;
35 (5) Comply with all data collection and reporting requirements
36 established by the commissioner;

1 (6) Provide the following:
2 (A) Financial reports and information to the commissioner
3 *as required by the commissioner in rules applicable to risk-based provider*
4 *organizations; and*
5 (B) Practice and clinical support to direct service
6 providers; and
7 (7) Manage the following:
8 (A)(i) Global capitated payments and the attendant
9 financial risks for delivery of services to the *enrollable* Medicaid
10 beneficiary populations.
11 (ii) The Department of Human Services shall develop
12 actuarially sound capitated rates for a defined scope of services under a
13 *risk methodology that may include risk adjustments, reinsurance, and stop-*
14 *loss* funding methods; and
15 (B)(i) Incentive payments received from the Department of
16 Human Services when quality and outcome measures are achieved.
17 *(ii) The Department of Human Services shall develop*
18 *rules, in consultation with direct service providers for individuals with*
19 *behavioral health needs and individuals with intellectual and development*
20 *disabilities, establishing criteria for quality incentive payments to*
21 *encourage and* reward delivery of high-quality care and services by a risk-
22 based provider organization.
23
24 20-77-2707. Reporting and performance measures.
25 (a)(1) On a quarterly basis, a risk-based provider organization shall
26 submit to the Department of Human Services protected health information for
27 *each member of a covered Medicaid beneficiary population and a voluntary*
28 *Medicaid beneficiary population enrolled with the* risk-based provider
29 organization in accordance with standards and procedures adopted by the
30 department, including without limitation:
31 (A) Claims data, including without limitation:
32 (i) Denial rates; and
33 (ii) Claims-paid rates;
34 (B) Encounter data;
35 (C) Unique identifiers;
36 (D) Geographic and demographic information;

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

1 and
2 (2) May promulgate rules as necessary to implement this
3 subchapter.
4
5 SECTION 2. Arkansas Code § 19-5-985(b)(1), concerning the Arkansas
6 Medicaid Program Trust Fund, is amended to read as follows:
7 (b)(1) The fund shall consist of the following:
8 (A) All revenues derived from taxes levied on soft drinks
9 sold or offered for sale in Arkansas under the Arkansas Soft Drink Tax Act, §
10 26-57-901 et seq., there to be used exclusively for the state match of
11 federal funds participation under the Arkansas Medicaid Program;
12 (B) The additional ambulance annual fees stated in § 20-
13 13-212;
14 (C) The special revenues specified in §§ 19-6-301(156) and
15 19-6-301(236); ~~and~~
16 (D) Payments from surety bonds issued regarding risk-based
17 provider organizations, as defined in § 20-77-2703; and
18 (E) The amounts collected under §§ 26-57-604 and 26-57-605
19 above the forecasted level for insurance premium taxes set by the Chief
20 Fiscal Officer of the State under § 10-3-1404(a)(1)(A).
21
22 SECTION 3. Arkansas Code Title 23, Chapter 61, Subchapter 1, is
23 amended to add an additional section to read as follows:
24 23-61-117. Risk-based provider organizations.
25 (a) The Insurance Commissioner shall regulate the licensing and
26 financial solvency of risk-based provider organizations, as defined in § 20-
27 77-2703, participating in the Medicaid provider-led organized care system for
28 *enrollable* Medicaid beneficiary populations as defined in § 20-77-2703.
29 (b) The commissioner may:
30 (1) Issue rules to implement this section;
31 (2) Impose and collect a reasonable fee from a risk-based
32 provider organization for the regulation and licensing of the risk-based
33 provider organization as established by rule of the State Insurance
34 Department; and
35 (3)(A) Administer collection of *the quarterly tax* imposed on
36 risk-based provider organizations under § 26-57-603 pursuant to a rule issued

1 by the department.
2 (B) The commissioner shall prescribe the reporting, forms,
3 and requirements related to the payment of *the quarterly tax* in a rule issued
4 by the department.
5
6 SECTION 4. Arkansas Code § 26-57-603, concerning tax reports and the
7 insurance premium tax, is amended to add an additional subsection to read as
8 follows:
9 (f)(1) A risk-based provider organization that is licensed under the
10 Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq., and § 23-61-
11 117 and participates in the Medicaid provider-led organized care system
12 offered by the Arkansas Medicaid Program for *enrollable* Medicaid beneficiary
13 populations as defined in § 20-77-2703 shall pay to the Treasurer of State
14 through the commissioner a tax imposed for the privilege of transacting
15 business in this state.
16 (2) The tax shall be computed at a rate of two and one-half
17 percent (2½%) on the total amount of funds received in global payments as
18 defined under § 20-77-2703 to a risk-based provider organization
19 participating in the Medicaid provider-led organized care system.
20 (3) The tax shall be:
21 (A) Reported at such times and in such form and context as
22 prescribed by the commissioner; and
23 (B) Paid on a quarterly basis as prescribed by the
24 commissioner.
25
26 SECTION 5. Arkansas Code § 26-57-604(a)(1)(B), concerning the
27 remittance of insurance premium tax and credit for noncommissioned salaries
28 and wages of employees of the insurers, is amended to add an additional
29 subdivision to read as follows:
30 (iii) The credit shall not be applied as an offset
31 against the premium tax on collections resulting from an eligible individual
32 insured under the Arkansas Medicaid Program as administered by a risk-based
33 provider organization.
34
35 SECTION 6. Arkansas Code § 26-57-610(b), concerning the disposition of
36 the insurance premium tax, is amended to add an additional subdivision to

1 read as follows:
2 (5) The taxes based on premiums collected under the Arkansas
3 Medicaid Program as administered by a risk-based provider organization shall
4 be:
5 (A) At the time of deposit, separately certified by the
6 commissioner to the Treasurer of State for classification and distribution
7 under this section;
8 (B)(i) Transferred in amounts not less than fifty percent
9 (50%) of the taxes based on premiums collected under the Arkansas Medicaid
10 Program as administered by a risk-based provider organization to the
11 designated account created by § 20-48-1004 within the Arkansas Medicaid
12 Program Trust Fund to solely provide funding for home and community-based
13 services to individuals with intellectual and developmental disabilities
14 until the Department of Human Services certifies to the Department of Finance
15 and Administration that the waiting list for the Alternative Community
16 Services Waiver Program, also known as the "Developmental Disabilities
17 Waiver", is eliminated.
18 (ii) On and after the certification as described in
19 subdivision (b)(5)(B)(i) of this section, all amounts of the taxes based on
20 premiums collected under the Arkansas Medicaid Program as administered by a
21 risk-based provider organization shall be transferred as described in
22 subdivision (b)(5)(C) of this section; and
23 (C) On and after the certification as described in
24 subdivision (b)(5)(A) of this section and after the transfer under
25 subdivision (b)(5)(B)(i) of this section, transferred in the remainder to the
26 Arkansas Medicaid Program Trust Fund and used as provided by § 19-5-985 as
27 well as being used to provide funding for:
28 (i) The quality incentive pool under § 20-77-2701 et
29 seq.;
30 (ii) Home and community-based services for
31 *individuals with behavioral health needs and intellectual and developmental*
32 *disabilities; and*
33 (iii) Other services covered by the Arkansas
34 Medicaid Program as determined by the Department of Human Services.
35
36 SECTION 7. DO NOT CODIFY. Implementation of Medicaid Provider-Led

1 Organized Care Act.
2 (a) The Medicaid Provider-Led Organized Care Act, § 20-77-2701 et
3 seq., shall be implemented as follows:
4 (1) On or before June 1, 2017, the Insurance Commissioner shall
5 adopt rules for the licensure of risk-based provider organizations to
6 implement the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq.;
7 (2)(A) On or before July 1, 2017, an organization seeking
8 conditional licensure in state for fiscal year 2018 to become a risk-based
9 provider organization shall submit an application to the commissioner.
10 (B) An organization may receive conditional license as a
11 risk-based provider organization upon demonstration of a governing board and
12 sufficient agreements with various providers of medical goods and services.
13 (C) A license issued conditionally shall expire on
14 December 31, 2017, or a later date as established by the commissioner;
15 (3) On or before October 1, 2017, an organization with
16 conditional license shall:
17 (A) Be capable of enrolling members of *enrollable* Medicaid
18 beneficiary populations into the risk-based organization;
19 (B) Demonstrate to the approval of the commissioner the
20 ability to establish an adequate medical service delivery network; and
21 (C)(i) Provide evidence of a bond issued by a surety
22 authorized to do business in this state in the amount of two hundred fifty
23 thousand dollars ($250,000).
24 (ii) The bond shall provide that the surety and the
25 organization shall be jointly and severally liable for payment of the bond
26 amount in the event the organization abandons efforts to obtain full
27 licensure.
28 (iii) Any payouts on a bond issued under this
29 section shall be paid to the Arkansas Medicaid Program Trust Fund;
30 (4) On or before January 1, 2018, an organization with
31 conditional license shall demonstrate to the commissioner that it has met the
32 solvency and financial requirements for a risk-based organization as
33 established by the commissioner; and
34 (5) On or before April 1, 2018, or a later date established by
35 the commissioner, an organization with conditional license shall demonstrate
36 to the commissioner that the organization is capable of assuming the risk of

1 a global payment and arranging for provision of healthcare services to the
2 *enrollable* Medicaid beneficiary populations.
3 (b)(1) Failure to comply with any one (1) of the milestones outlined
4 in subsection (a) of this section shall be grounds for termination of a
5 conditional licensure or full licensure.
6 (2) The commissioner shall award full licensure to a risk-based
7 provider organization with conditional licensure if the organization timely
8 meets each of the milestones outlined in subsection (a) of this section.
9 (3) Failure by an organization to timely meet one (1) or more of
10 the milestones outlined in subsection (a) of this section shall not prevent
11 the commissioner, in his or her sole discretion, from granting full licensure
12 to the organization as long as the organization has met all of the milestones
13 outlined in subsection (a) of this section by January 1, 2018, or a later
14 date established by the commissioner.
15 (c) Implementation of the Medicaid Provider-Led Organized Care Act, §
16 20-77-2701 et seq., shall not be considered a rule under the Arkansas
17 Administrative Procedure Act, § 25-15-201 et seq.
18
19 SECTION 8. EMERGENCY CLAUSE. It is found and determined by the
20 General Assembly of the State of Arkansas that the current method of serving
21 the *enrollable* Medicaid beneficiary populations is resulting in excessive and
22 unnecessary costs to the Arkansas Medicaid Program and to the State of
23 Arkansas; that the *enrollable* Medicaid beneficiary populations are growing at
24 a rate that is unsustainable under the current method of serving the
25 *enrollable* Medicaid beneficiary populations; that the Medicaid provider-led
26 organized care system will improve quality and efficiencies of healthcare
27 services to *enrollable* Medicaid beneficiary populations by enhancing the
28 performance of the broader healthcare system with increased access to care;
29 that the Medicaid Provider-Led Organized Care Act requires healthcare
30 providers to create, present to the Department of Human Services and the
31 Insurance Commissioner for approval, implement, and market a new kind of
32 organization that offers a type of health insurance; and that this act is
33 immediately necessary to ensure efficient use of taxpayer dollars and to
34 provide healthcare providers certainty about the law creating the Medicaid
35 Provider-Led Organized Care Act before fully investing time, funds,
36 personnel, and other resources to the development of the new risk-based

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

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

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

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

/s/Pilkington

APPROVED: 03/31/2017