State of Arkansas  
90th General Assembly  
Second Extraordinary Session, 2016  

By: Senator J. Hendren  
By: Representative Collins  

For An Act To Be Entitled  
AN ACT TO CREATE THE ARKANSAS MEDICAID REFORM ACT OF 2016; TO LIMIT THE SCOPE OF MANAGED CARE INSURANCE PRODUCTS IN ARKANSAS; TO ESTABLISH A BILL OF RIGHTS FOR MANAGED CARE IN ARKANSAS; TO APPLY MEDICAID SAVINGS TO THE WAIT LIST OF THE ALTERNATIVE COMMUNITY SERVICES WAIVER, ALSO KNOWN AS THE "DEVELOPMENTAL DISABILITIES WAIVER"; TO REFORM THE ARKANSAS MEDICAID PROGRAM TO IMPROVE PATIENT OUTCOMES; AND FOR OTHER PURPOSES.

Subtitle  
TO CREATE THE ARKANSAS MEDICAID REFORM ACT OF 2016.

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 — Arkansas Medicaid Reform Act of 2016

20-77-2701. Title.
This subchapter shall be known and may be cited as the "Arkansas Medicaid Reform Act of 2016".

20-77-2702. Legislative intent.
(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 XIX of the Social Security Act, 42 U.S.C. § 1397aa et seq., the Department of Human Services of this state is authorized by federal law to contract with two (2) or more Medicaid managed care organizations for providing medically necessary goods and services to Medicaid beneficiaries.

(b) The purpose of this subchapter is to:

(1) Limit and define the populations and services subject to Medicaid managed care insurance;
(2) Provide for a smooth, efficient, and safe transition from traditional fee-for-service Medicaid to a capitated comprehensive-risk managed care insurance program for limited populations; and
(3) Protect the best interests of the patients, healthcare providers, and the taxpayers of the State of Arkansas.

(c) It is the intent of the General Assembly that any managed care organization contract entered into by the department shall:

(1) Generate savings to reduce the wait list of the Alternative Community Services Waiver, commonly known as the "Developmental Disabilities Waiver", and ensure the long-term stability of the Arkansas Medicaid Program;
(2) Improve the experience of health care, including without limitation quality of care, access to care, and reliability of care, for covered Medicaid beneficiaries;
(3) Adhere to a patient and provider bill of rights, as adopted by the General Assembly, at all times during the procurement process and during the term and operation of the contract;
(4) Enhance the performance of the broader healthcare system leading to improved overall population health;
(5) Slow or reverse spending growth for covered populations and services while maintaining quality of care and access to care;
(6) Further the objectives of Arkansas payment reforms and the state's ongoing commitment to innovation;
(7) Discourage overutilization of services;
(8) Reduce waste, fraud, and abuse; and
(9) Encourage the most efficient use of taxpayer funds.

20-77-2703. Definitions.
As used in this subchapter:

(1) "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;

(2) "Healthcare provider" means an individual or entity subcontracted by or in a provider agreement with a managed care organization to provide medical goods and services directly to members;

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

(A) Obligated under a comprehensive 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;

(4) "Medicaid" means the programs authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. and Title XIX of the Social Security Act, 42 U.S.C. § 1397aa et seq., as existing on January 1, 2016, for the provision of medical goods and services to qualified beneficiaries;

(5) "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; and

(6) "Member" means a Medicaid beneficiary enrolled into a plan of health insurance coverage offered through a managed care organization.

20-77-2704. Covered populations and services.

(a)(1) The Department of Human Services shall not enter into a comprehensive risk contract with a managed care organization except as authorized in this subchapter.

(2) The department shall enter into a comprehensive risk contract with two (2) or more managed care organizations:

(A) For the following Medicaid populations:

(i)(a) Individuals who have an intellectual disability, developmental disability, developmental delay, or medical
condition that creates a risk for developmental delay.

(b) An individual residing in a human development center operated by the department under the authority of the Board of Developmental Disabilities Services is excluded;

(ii) Individuals with significant behavioral health needs; and

(iii) Individuals who require long-term care services and supports and who are either:

(a) Over sixty-five (65) years of age,

(b) Blind; or

(c) Disabled; and

(B) For dental services to all Medicaid beneficiaries.

(3) The department shall not enter into a comprehensive risk contract with a managed care organization for the populations described in subdivision (a)(2)(A)(iii) of this section if:

(A) The department 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, no later than June 1, 2016, to implement specific proposals to reform the payment and implementation of long-term care services and supports, including without limitation an independent assessment to determine level of acuity, patient needs, and tiered care delivery structure;

(B) The approved reforms generate savings to the State of Arkansas of at least fifty million dollars ($50,000,000) each year for at least two (2) years between January 1, 2017 and December 31, 2019;

(C) 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 subdivision (a)(3)(A) of this section; and

(D) The savings realized by the reforms are verified by an independent actuary selected by the department.

(b) The department may permit a managed care organization to enroll qualifying Medicaid beneficiaries statewide or within a geographic region defined by the department.

(c) A comprehensive full-risk contract between the department and a managed care organization shall comply with the provisions of this
(d) Within sixty (60) days of the effective date of this subchapter, the department shall provide an outline to the Legislative Council to address plans described in this section, including a proposed timeline.

20-77-2705. Providers.
(a) A managed care organization may provide goods and services that will lead to positive health outcomes directly to Medicaid beneficiaries or through:

(1) A healthcare provider directly employed or owned by the managed care organization;

(2) A healthcare provider subcontracted by the managed care organization; or

(3) An independent healthcare provider that entered into a provider agreement with the managed care organization.

(b) The mutual agreement between the managed care organization and the provider shall determine without regard to rules established by the Department of Human Services or by state law:

(1) The payment rates of the managed care organization to the provider; and

(2) The policies and procedures relating to the goods and services of the provider.

20-77-2706. Reporting.
(a)(1) A managed care organization that has contracted with the Department of Human Services shall, in accordance with the standards and procedures adopted by the department, submit to the department protected health information for each Medicaid beneficiary enrolled with the managed care organization, including without limitation:

(A) Claims data;

(B) Encounter data;

(C) Unique identifiers; and

(D) Geographic and demographic information.

(2) Personally identifiable data submitted under subdivision (a)(1) of this section is confidential and exempt from disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq.
(b) At least quarterly, 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) Managed care organization enrollment and population distribution;
   
   (2) Patient experience with managed care organization and healthcare providers; and
   
   (3) Financial performance, including without limitation demonstrated savings.

20-77-2707. Member rights.

(a) A member shall be entitled to:

   (1) A plan of health insurance coverage offered through a managed care organization that:

      (A) Establishes one (1) or more community advisory committees that includes advocates and members;
      
      (B) Does not reduce the types of services and benefits established by the state;
      
      (C) Does not place utilization limits on the number of medically necessary visits by a member to a primary care provider;
      
      (D) Offers member-centric programs, including without limitation rewarding healthy behaviors; and
      
      (E) For a member with multiple chronic conditions or disabilities, provides a whole-health integrated care approach for benefits in which the member has qualified;
      
   (2) The right to choose a Medicaid primary care provider; and
   
   (3) The enrollment in a patient-centered medical home to ensure the continuity of care.

(b) This section shall apply only to the Medicaid populations listed under § 20-77-2704(a)(2)(A).

20-77-2708. Healthcare provider rights.

(a) A healthcare provider shall be entitled to a plan of health insurance coverage offered through a managed care organization that:

   (1) Pays:

      (A) The healthcare provider no less than the prevailing
Medicaid fee schedule, unless mutually agreed upon by the provider and managed care organization;

(B) Ninety-nine percent (99%) of the clean provider claims within thirty (30) days of the receipt by the managed care organization; and

(C) The prevailing dispensing fee rate for pharmacies, unless mutually agreed upon by the provider and managed care organization;

(2) Offers a provider agreement to all safety-net healthcare providers, including without limitation:

(A) Federally qualified health centers;

(B) Rural health clinics; and

(C) Critical-access hospitals;

(3) Establishes healthcare provider advisory committees to consider:

(A) Healthcare provider compensation;

(B) Healthcare provider credentialing;

(C) Pharmacy and therapeutics; and

(D) Quality improvement;

(4) Enters into contract negotiations with any willing healthcare provider;

(5) Uses a standard credentialing process to ease administrative resources; and

(6) Provides reporting to healthcare providers on utilization and other metrics, as established by rule of the Department of Human Services.

(b) This section shall apply only to the Medicaid populations listed under § 20-77-2704(a)(2)(A).

20-77-2709. Taxpayer protection.

(a) A plan of health coverage offered through a managed care organization shall:

(1) Ensure transparency through quarterly reporting to the Legislative Council, or the Joint Budget Committee if the General Assembly is in session, that measures the following performance metrics for all healthcare providers:

(A) Patient outcomes;

(B) Access to healthcare services; and
(C) Costs;

(2) Offer care coordination services through staff physically located within Arkansas;

(3) Publish an annual report card to demonstrate health outcomes of the plan of health insurance coverage offered through the managed care organization; and

(4) Formulate actuarially sound rates for members in an open and transparent process.

(b)(1) The Department of Human Services shall establish a medical loss ratio that ensures a portion of substantial savings be returned to the State of Arkansas.

(2) The state shall be the final arbitrator of what constitutes administrative costs and medical costs of a managed care organization.

(3) A portion of the savings described in subdivision (b)(1) of this section shall be used to serve individuals who have developmental disabilities and who are not currently receiving services through the Alternative Community Services Waiver Program operated by the department.

(c) Existing Medicaid reform initiatives developed by the department may continue to be operated and expanded, including without limitation:

(1) The Arkansas Patient-Centered Medical Home Program; and

(2) The Arkansas Health Care Payment Improvement Initiative.

(d) This section shall apply only to the Medicaid populations listed under § 20-77-2704(a)(2)(A).

20-77-2710. Rulemaking and waiver authority.

(a) The Department of Human Services may:

(1) Submit and apply for any federal waivers or state plan amendments necessary to implement this subchapter; and

(2) Promulgate rules to implement and administer this subchapter.

(b) Notwithstanding any other state law or rule, a managed care organization administering the Arkansas Medicaid Program is not authorized or required to promulgate, through the Arkansas Administrative Procedure Act, § 25-15-201 et seq., its policies and procedures for participating providers, including without limitation rules, standards, or criteria.
SECTION 2. Arkansas Code § 20-77-1702(7), concerning the definition of "department" within the Medicaid Fairness Act, is amended to read as follows:

(7)(A) "Department" means:

(A)(i) The Department of Human Services;

(B)(ii) All the divisions and programs of the Department of Human Services, including the state Medicaid Program;

(C)(iii) All the department’s contractors, fiscal agents, and other designees and agents of the Department of Human Services.

(B) "Department" does not include a managed care organization that provides or pays for medical services for beneficiaries through a comprehensive risk contract with the Department of Human Services;

SECTION 3. Arkansas Code § 20-77-1702(11), concerning the definition for "Medicaid" within the Medicaid Fairness Act, is amended to read as follows:

(11)(A) "Medicaid" means the medical assistance program 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., that is operated by the department, including contractors, fiscal agents, and all other designees and agents;

(B) "Medicaid" does not include a managed care organization that provides or pays for medical services for beneficiaries through a comprehensive risk contract with the Department of Human Services;

SECTION 4. Arkansas Code Title 19, Chapter 5, Subchapter 11, is amended to add an additional section to read as follows:


(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) 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; and

(4) Other purposes at the direction of the Director of the Department of Human Services.

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 managed care 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:

(4)(A) The taxes based on premiums collected under the Arkansas Medicaid Program as administered by a managed care organization shall be, at the time of deposit, separately certified by the commissioner to the Treasurer of State for classification and distribution under this section.

(B)(i) The Chief Fiscal Officer of the State shall transfer all or a portion that he or she deems appropriate, upon consultation with the Governor, of the taxes based on premiums collected under the Arkansas Medicaid Program as administered by a managed care organization to the Community Living and Employment Supports Trust Fund and used as provided by the Community Living and Employment Supports Trust Fund.

(ii) Any portion of the taxes based on premiums collected under the Arkansas Medicaid Program as administered by a managed care organization that are not transferred under subdivision (b)(4)(B)(i) of this section shall be credited to the various State Treasury funds.
participating in general revenues in the respective proportions to each as
provided by and to be used for the respective purposes set forth in the
Revenue Stabilization Law, § 19-5-101 et seq.
Non-technical Description of
Arkansas Medicaid Reform Act of 2016

Section 1

§ 20-77-2701. Title: “Arkansas Medicaid Patient Outcome Reform Act of 2016; to limit the scope of managed care insurance products in Arkansas; to apply Medicaid savings to the wait list of the alternative community service waiver; and to reform the Arkansas Medicaid program to improve patient outcomes.”

§ 20-77-2702. Purpose and legislative intent.

The State is pursuing this effort to enhance health outcomes for Medicaid patients, moving away from a system that pays for the volume of care delivered. The State will instead pay managed care organizations (MCO) to coordinate care for patients and deliver the right care at the right time, before chronic conditions require expensive interventions. These reforms will also allow the State to continue its recent steps to reduce waste, fraud, and abuse.

However, any effort to utilize managed care for the State’s traditional high-cost population must incorporate a list of requirements, which has been passed by the legislature and protects patients, providers and State tax payers.

§ 20-77-2803. Definitions.

Managed care companies will be authorized to operate in the State by Arkansas Department of Insurance (DOI), but will contract with the Department of Human Services (DHS) for a set amount per patient. These rates will be actuarially sound, and any cost overruns will be borne by the managed care company.

§ 20-77-2804. Covered populations and services.

The State will be authorized to pursue managed care only for individuals with:
1. an intellectual disability;
2. a developmental disability;
3. developmental delay;
4. medical conditions which create a risk for developmental delay; or
5. significant behavioral health needs.

The State shall authorize managed care for the long-term services and supports populations, including those treated in nursing homes and home- and community-based settings, if the State does not meet reduced growth goals of $50,000,000 per year in two (2) of the first three (3) years (2017, 2018 or 2019) of the agreement with the long-term care providers. The State must also submit State plan amendments or
make administrative rule changes to comply with the agreement. Finally, the savings must be certified by an independent actuary.

§ 20-77-2805. Providers.

Managed care companies will be authorized to subcontract with providers in the State to provide services to Medicaid enrollees.

§ 20-77-2806. Reporting.

MCOs will be required to submit information on their enrollees, including claims, encounter, unique identifier, geographic and demographic data.

DHS will be required to report data quarterly to the Legislative Council on how enrollment is dispersed across various MCOs, statistics related to patient experience and the financial performance (including savings) of the MCOs.

MCOs will report data more frequently to DHS, and those requirements will be broken out in the request for proposal.

**Patient, Provider, and Taxpayer Bill of Rights**

§ 20-77-2707. Member Rights

Conditions to which MCOs must adhere regarding members include:

- Establish one (1) or more community advisory committees that include(s) advocates and members;
- Cannot reduce the types of services and benefits established by the State;
- Not place utilization limits on the number of medically necessary visits by a member to a primary care provider;
- Offer member-centric programs, including rewards for healthy behaviors;
- Provide a whole-health integrated care approach;
- Allow a member to choose a Medicaid primary-care provider;
- Enroll members in a patient-centered medical home to ensure their continuity of care;
- Dental managed care is exempt.

§ 20-77-2708. Healthcare provider rights

Conditions MCOs will be required to adhere to regarding providers include:

- Providers will be paid no less than the prevailing Medicaid fee scheduled, unless they mutually agree with the MCO to receive less.
- 99% of all clean provider claims must be processed within 30 days of the receipt by the MCO.
- Pharmacists will be paid the prevailing dispensing fee unless they reach an agreement with the MCO to receive less;
- All safety net healthcare providers must be offered an agreement, including federally-qualified health centers, rural health clinics and critical-access hospitals;
- Must establish provider advisory committees to consider compensation, credentialing, pharmacy and therapeutics, and quality improvement;
- Must enter contract negotiations with any willing provider;
- Use a standard credentialing process;
- Provide reporting to healthcare providers on utilization and other metrics established by DHS.

§ 20-77-2709. Taxpayer protection.

Conditions MCOs will be required to adhere to for the State include:

- Quarterly reporting to the legislative council or the joint budget committee on patient outcomes, access to healthcare services and costs;
- Care coordination services through staff physically located within Arkansas;
- Publish annual report cards to demonstrate health outcomes;
- Formulate actuarially sound rates for members in an open and transparent process;
- DHS will establish a medical loss ratio formula that ensures a portion of substantial savings will be returned to the State.
- A portion of the savings will be directed to serve individuals who have developmental disabilities (DD) and are not currently receiving services through the DD waiver.

§ 20-77-2710. Waiver authority -- rulemaking authority.

The State is authorized to pursue the necessary waivers to implement managed care.

Sections 2 & 3

Amendments are made to sections § 20-77-1702(7) and § 20-77-1702(11), clarifying that MCOs are not Medicaid. With these changes, MCOs will be able to sanction providers, recoup payments due to fraud, waste, or abuse, and utilize prior authorizations to ensure appropriate care is provided in the correct setting. A channel of appeal will remain with the State.
Section 4


This section establishes the trust fund to be used to reduce the developmentally disabled waiver wait list and directs a portion of the new premium tax raised by the managed care contracts to reduce the wait list.

Section 5
This eliminates the tax credit MCOs could apply to the premium tax they pay, increasing savings for the State.

Section 6
This section establishes the certification and disbursement of incoming premium taxes as a result of payments to MCOs and clarifies that the State chief fiscal officer is responsible for certifying the amount that is released to address the DD waitlist.