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4

A Bill

DRAFT JMB/JMB
HOUSE BILL

5 By: Representatives M. Gray, Boyd, D. Ferguson, Farrer
6 By: Senators Irvin, J. Cooper, K. Ingram, L. Chesterfield
7

For An Act To Be Entitled

8
9 AN ACT TO CREATE THE DIAMONDCARE ACT OF 2016; TO
10 IMPLEMENT MANAGED FEE-FOR-SERVICES ON CERTAIN
11 MEDICAID POPULATIONS; TO REFORM THE ARKANSAS MEDICAID
12 PROGRAM; AND FOR OTHER PURPOSES.
13
14

Subtitle

15
16 TO CREATE THE DIAMONDCARE ACT OF 2016; TO
17 IMPLEMENT MANAGED FEE-FOR-SERVICES ON
18 CERTAIN MEDICAID POPULATIONS; AND TO
19 REFORM THE ARKANSAS MEDICAID PROGRAM.
20
21

22 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
23

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

26 Subchapter 27 – Diamondcare Act of 2016

27
28 20-77-2701. Title.

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

31
32 20-77-2702. Legislative intent.

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

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

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

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

4 (B) Results-oriented system of coordinated care that:
5 (i) Focuses on independence and choice;
6 (ii) Maximizes available service options;
7 (iii) Promotes accountability and transparency;
8 (iv) Encourages and rewards healthy outcomes and
9 responsible choices; and

10 (v) Promotes efficiencies through interdepartmental
11 cooperation.

12
13 20-77-2703. Definitions.

14 As used in this subchapter:

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

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

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

26 (A) Assessment and evaluation;

27 (B) Triage;

28 (C) Referral; and

29 (D) Time-limited outpatient services;

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

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

36 (A) Align the assessment process with an individualized

1 plan of care;

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

4 (C) Facilitate quality improvement initiatives; and

5 (D) Allow for monitoring of outcomes;

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

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

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

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

18 (B) The enhanced ambulatory procedure grouping system;

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

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

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

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

1 (A) Prevocational services;

2 (B) Educational services; and

3 (C) Supported employment services;

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

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

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

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

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

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

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

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

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

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

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

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

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

7 (A) Independent assessment;

8 (B) Prior authorization;

9 (C) Plan of care;

10 (D) Utilization management;

11 (E) Quality assurance;

12 (F) Outcomes measurement;

13 (G) Call center services;

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

15 (I) Cost comparison to a specific benchmark;

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

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

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

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

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

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

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

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

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

7 (ii) Lower payments for events and procedures that:

8 (a) Were avoidable;

9 (b) Do not promote quality; and

10 (c) Increase costs.

11
 12 20-77-2704. Managed fee-for-service organization model.

13 (a) The Department of Human Services shall:

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

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

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

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

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

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

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

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

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

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

1 beneficiaries;

2 (3) Prior authorization; and

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

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

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

8 (2) Assure person-centered planning;

9 (3) Provide beneficiary choice of healthcare providers;

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

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

14
 15 20-77-2705. Patient-centered medical home program.

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

18 (b) The Department of Human Services shall:

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

22 (2) Identify:

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

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

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

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

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

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

36 (B) The strategy for care management and care coordination

1 may include without limitation:

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

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

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

10
11 20-77-2706. Dental managed care.

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

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

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

21
22 20-77-2707. Monitoring of quality of care – Financial risk.

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

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

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

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

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

5
 6 20-77-2708. Value-based purchasing strategy.

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

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

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

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

20 (A) Quality reporting for Medicaid providers;

21 (B) Health homes for Medicaid beneficiaries who are:

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

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

25 (iii) Diagnosed with severe and persistent mental
 26 illness;

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

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

31
 32 20-77-2709. Project management.

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

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

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

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

- 9 (1) The current status of the implementation;
- 10 (2) The anticipated timeline for the implementation;
- 11 (3) Any major milestones achieved;
- 12 (4) All implementation risks; and
- 13 (5) Any changes to the timeline described in subdivision (c)(2)

14 of this section.

15
 16 20-77-2710. Dashboard for operation metrics.

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

20 (b) The online dashboard shall include without limitation:

- 21 (1) The number of applications received and processed;
- 22 (2) The total enrollment numbers by eligibility group;
- 23 (3) The new enrollment numbers by eligibility group since the
 24 last reporting;
- 25 (4) The amount and number of paid claims by eligibility group;
- 26 (5) The number of payments made for healthcare services
 27 associated with labor and delivery;
- 28 (6) Medicaid provider performance measures;
- 29 (7) Performance metrics for key contracts with the program;
- 30 (8) Performance of all major savings initiatives contained in
 31 this subchapter and any other program reform measures;

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

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

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

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

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

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

13
14 20-77-2711. Diagnosis-related group methodology for hospitals.

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

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

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

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

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

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

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

35 (2) The conversion plan shall:

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

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

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

7
8 20-77-2712. Independent annual Medicaid provider rate review.

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

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

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

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

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

24 (A) Other state Medicaid programs;

25 (B) Medicare; and

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

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

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

34 (B) The implementation plan shall include without
35 limitation:

36 (i) A draft of the scope of work;

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

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

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

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

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

14
15 20-77-2713. Administration of the global waiver.

16 (a) The Department of Human Services shall:

17 (1) Apply for:

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

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

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

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

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

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

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

1 Public Health, Welfare, and Labor.

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

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

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

19
20 20-77-2714. Provisional rates of nursing homes.

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

25
26 20-77-2715. Long-term care and developmental disabilities.

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

31 (1)(A) An independent assessment.

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

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

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

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

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

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

6 (E) The department may by rule:

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

9 (ii) Select a different independent assessment
10 instrument;

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

15 (3) Person-centered planning;

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

17 (5) Independent case management; and

18 (6) Assurance of dignity for the patient.

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

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

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

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

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

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

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

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

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

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

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

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

15 (d) The department shall:

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

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

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

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

30
31 20-77-2716. Behavioral health and mental health services.

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

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

1 organization; and

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

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

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

9 (A) Psychiatric emergency services;

10 (B) Brief intervention services;

11 (C) Illness management and recovery;

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

14 (E) Day supportive services;

15 (F) Integrated dual disorders treatments;

16 (G) Identified cognitive behavioral therapies; and

17 (H) Dialectical behavioral therapy.

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

20 (A) Cognitive behavioral therapies for specified
 21 disorders;

22 (B) Multisystemic individual therapy and family therapy;

23 (C) Trauma-informed therapy;

24 (D) Group therapy for specified disorders; and

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

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

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

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

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

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

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

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

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

10 (1) Eligibility determinations;

11 (2) Plans of care for a Medicaid beneficiary;

12 (3) Prior authorizations;

13 (4) Utilization reviews; and

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

17 (B) The independent assessments used shall be:

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

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

23 (C) The department may by rule:

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

26 (ii) Select a different independent assessment
27 instrument; or

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

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

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

35 (2) When prior authorization has been approved.

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

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

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

7 (2) Psychiatric inpatient services;

8 (3) Residential treatment centers;

9 (4) The Arkansas State Hospital; and

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

12
 13 20-77-2717. Child health management services and developmental day
 14 treatment clinic services.

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

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

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

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

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

25 (b) The comprehensive plan shall include without limitation:

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

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

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

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

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

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

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

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

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

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

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

26
27 20-77-2718. Provider reimbursement withholdings – Provider Withholding
28 Account.

29 (a)(1)(A) The Department of Human Services shall withhold two percent
30 (2%) of provider reimbursement to a developmental disability services
31 provider, a behavioral health services provider, and a child health
32 management services provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36

1 20-77-2719. Limitations on multiple provider numbers.

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

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

11
12 20-77-2720. Savings within long-term care.

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

- 18 (A) Sixty-five (65) years of age or older;
19 (B) Blind; or
20 (C) Disabled.

21 (2) The memorandum of understanding shall include:

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

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

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

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

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

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

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

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

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

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

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

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

26
27 20-77-2721. Duties of Legislative Council meeting in conjunction with
28 the Senate Committee on Public Health, Welfare, and Labor and the House
29 Committee on Public Health, Welfare, and Labor.

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (B) Recommendations for any changes to the program.

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

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

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

1 Legislative Council meeting in conjunction with the Senate Committee on
2 Public Health, Welfare, and Labor and the House Committee on Public Health,
3 Welfare, and Labor to meet during a recess as authorized by § 10-2-223 or §
4 10-3-211.

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

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

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

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

15
16 20-77-2722. Rule-making authority.

17 (a) The Department of Human Services shall:

18 (1) Promulgate rules to implement this subchapter; and

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

21 (b) This subchapter does not preclude:

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

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

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

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

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

34
35 SECTION 2. Arkansas Code Title 19, Chapter 5, Subchapter 11, is
36 amended to add an additional section to read as follows:

1 19-5-1146. Community Living and Employment Supports Trust Fund.

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

5 (b) The fund shall consist of:

6 (1) Premium tax collections transferred to the fund under § 26-
 7 57-610(b)(4)(B);

8 (2) Dental managed care cost savings; and

9 (3) Other revenues and funds authorized by law.

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

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

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

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

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

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

22
 23 SECTION 3. Arkansas Code § 26-57-604(a)(1)(B), concerning the
 24 remittance of insurance premium tax and credit for noncommissioned salaries
 25 and wages of employees of the insurers, is amended to add an additional
 26 subdivision to read as follows:

27 (iii) The credit shall not be applied as an offset
 28 against the premium tax on collections resulting from an eligible individual
 29 insured under the Arkansas Medicaid Program as administered by a managed care
 30 organization under § 20-77-2706.

31
 32 SECTION 4. Arkansas Code § 26-57-610(b), concerning the disposition of
 33 the insurance premium tax, is amended to add an additional subdivision to
 34 read as follows:

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

1 77-2706 shall be, at the time of deposit, separately certified by the
2 commissioner to the Treasurer of State and the Chief Fiscal Officer of the
3 State for classification and distribution under this section.

4 (B)(i) From time to time, the Chief Fiscal Officer of the
5 State shall transfer on his or her books and those of the State Treasurer and
6 the Auditor of the State each fiscal year up to fifteen million dollars
7 (\$15,000,000) or so much as is made available of the taxes based on premiums
8 collected under the program as administered by a managed care organization
9 under § 20-77-2706 to the Community Living and Employment Supports Trust
10 Fund.

11 (ii) Upon the determination of the Chief Fiscal
12 Officer of the State, that the annual amount to be transferred under
13 subdivision (b)(4)(B)(i) will be less than fifteen million dollars
14 (\$15,000,000), then the Chief Fiscal Officer of the State shall transfer on
15 his or her books and those of the State Treasurer and the Auditor of the
16 State general revenue in the Department of Human Services – Division of
17 Medical Services paying account in an amount necessary to insure a total
18 annual transfer of fifteen million dollars (\$15,000,000) authorized in this
19 section and in subdivision (b)(4)(B)(i) of this section to the Community
20 Living and Employment Supports Trust Fund.

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

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

28
29 SECTION 5. DO NOT CODIFY. Primary care providers – Pharmacy –
30 Healthcare reforms.

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

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

- 1 (1) Promote telemedicine for specialist services;
- 2 (2) Provide reimbursement for wellness exams and wellness
- 3 laboratory services for the adult population on the traditional Arkansas
- 4 Medicaid Program;
- 5 (3) Increase reimbursements for vaccinations;
- 6 (4) Eliminate the limitations on the number of office visits for
- 7 Medicaid beneficiaries who are enrolled in patient-centered medical homes;
- 8 (5) Increase or eliminate caps on laboratory services and
- 9 radiology services for Medicaid beneficiaries who are enrolled in patient-
- 10 centered medical homes; and
- 11 (6) Provide limited reimbursement for office visits for diabetes
- 12 self-management programs or diabetes management programs.
- 13 (c) The department shall make the following reforms to the pharmacy
- 14 program in the Arkansas Medicaid Program:
- 15 (1) Expand the preferred drug list;
- 16 (2) Include behavioral health medications and antipsychotic
- 17 medications on the preferred drug list;
- 18 (3) Change reviews of plans of care by a licensed psychiatrist
- 19 to patients seven (7) years of age and gradually increase the age of the
- 20 review to ten (10) years of age with evidence of continued cost-avoidance;
- 21 (4) Add an additional one hundred (100) medications to the
- 22 Competitive Acquisition Program;
- 23 (5) Eliminate prescription drug limits on maintenance
- 24 medications;
- 25 (6) Provide reimbursement for immunizations and vaccinations
- 26 within certain criteria and by referrals as determined by the department;
- 27 (7) Encourage the addition or inclusion of a community
- 28 pharmacist as a vital component of the Arkansas Patient-Centered Medical Home
- 29 Program;
- 30 (8) Increase reimbursements for vaccinations; and
- 31 (9)(A) Explore the National Average Drug Acquisition Cost
- 32 pricing model with a corresponding professional dispensing fee and the
- 33 multistate prescription drug list.
- 34 (B) The department shall report to the Governor, the
- 35 Legislative Council, the Senate Committee on Public Health, Welfare, and
- 36 Labor, the House Committee on Public Health, Welfare, and Labor, and the

1 Arkansas Health Reform Legislative Task Force:

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

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

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

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

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

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

17 (A) In a new enrollee orientation program; and

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

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

24
 25 SECTION 6. DO NOT CODIFY. TEMPORARY LANGUAGE. Timeline for
 26 implementation and reports.

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

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

32 (A) A functional project management plan;

33 (B) A timeline of implementation;

34 (C) A list of challenges and needed resources;

35 (D) Estimated program savings and administrative savings;

36 and

- 1 (E) A list of barriers and solutions;
- 2 (2) A schedule, purpose, and timeline of short-term and long-
- 3 term rule changes, waiver amendments, or state plan amendments needed to
- 4 implement this act; and
- 5 (3) A contingency plan addressing short-term and long-term
- 6 saving targets if the department is unable to implement any section of this
- 7 act in a timely fashion.

8

9 SECTION 7. DO NOT CODIFY. TEMPORARY LANGUAGE. Reform to

10 rehabilitative services for persons with mental illness.

11 (a) The Department of Human Services shall:

12 (1) Work with existing providers of rehabilitative services for

13 persons with mental illness to develop actions and reforms that will decrease

14 any duplication of services and unnecessary cost; and

15 (2) Complete the revision of the benefit for rehabilitative

16 services for persons with mental illness before the conversion of the

17 existing behavioral health and mental health system to an evidence-based and

18 best-practice system and any other reform model enacted by the General

19 Assembly.

20 (b) The Office of Medicaid Inspector General shall assist the

21 department in completing the revision of the benefit for rehabilitative

22 services for persons with mental illness.

23 (c) On or before October 1, 2016, the department shall report to the

24 Arkansas Health Reform Legislative Task Force, the Legislative Council, the

25 Senate Committee on Public Health, Welfare, and Labor, and the House

26 Committee on Public Health, Welfare, and Labor on improvement strategies to

27 be employed.

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