

RULE 117

PROVIDER-LED ORGANIZATION LICENSURE STANDARDS

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Section 1. Authority

This rule is issued pursuant to Ark. Code Ann. § 23-61-117(b) which authorizes the Arkansas Insurance Commissioner (“Commissioner”) to issue rules to regulate the licensure and financial solvency of risk-based provider organizations under Act 775 of 2017 of the 91st Arkansas General Assembly also known as the “Medicaid Provider-Led Organized Care Act” (hereafter, the “Organized Care Act”). In addition, Section Seven (7) of the Organized Care Act requires the Commissioner to adopt rules on or before June 1, 2017 to implement various provisions of the Act.

Section 2. Purpose

The purpose of this Rule is to establish licensure and solvency requirements of risk-based provider organizations (“RBPOs”) participating in the Organized Care Act. This Rule provides application requirements of the RBPO participating in the program, addresses standards for imposition of additional amounts of funds above reserve requirements to adjust to risk in Ark. Code Ann. § 20-77-2706

(f)(4)(B), establishes financial reporting requirements of the RBPO, imposes a reasonable fee for the regulation and licensing of the RBPO by rule under § 23-61-117(b)(2), and, finally, prescribes the reporting, forms, and requirements related to the payment of the quarterly tax under Ark. Code Ann. 23-61-117(b)(3).

Section 3. Applicability and Scope

A. Certificate of Authority Limited To Participation in the Organized Care Act Program.

This Rule applies to the licensure and solvency standards of RBPOs, as defined in Ark. Code Ann. § 20-77-2703(13) under the Organized Care Act. Nothing in this Rule is intended to sanction, permit or establish a process for a provider sponsored organization to obtain a certificate of authority to engage in risk assumption or risk sharing activities in this State, outside of its participation in the Organized Care Act program.

Section 4. Definitions

As used in this Rule:

- (1) "ADHS" means the Arkansas Department of Human Services;
- (2) "Associated participant" means an organization or individual that is a member or contractor of a risk-based provider organization and provides necessary administrative functions, including without limitation claims processing, data collection, and outcome reporting;
- (3) "Capitated" means an actuarially sound healthcare payment that is based on a payment per person that covers the total risk for providing healthcare services as provided in this subchapter for a person;
- (4)(A) "Care coordination" means the coordination of healthcare services delivered by healthcare provider teams to empower patients in their health care and to improve the efficiency and effectiveness of the healthcare sector.
- (B) "Care coordination" includes without limitation:
 - (i) Health education and coaching;

- (ii) Promoting linkages with medical home services and the healthcare system in general;
- (iii) Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;
- (iv) Assistance with social determinants of health, such as access to healthy food and exercise; and
- (v) Promotion of activities focused on the health of a patient and the community, including without limitation outreach, quality improvement, and patient panel management;

(B)(vi) Community-based management of medication therapy;

(5) "Carrier" means an organization that is licensed or otherwise authorized to provide health insurance or health benefit plans under § 23-85-101 or § 23-76-101;

(A) licensed or otherwise authorized to transact health insurance as an insurance company under § 23-62-103;

(B) authorized to provide healthcare plans under §23-76-108 as a health maintenance organization; or

(C) authorized to issue hospital service or medical service plans as a hospital medical service corporation under §23-75-108.

(6) "Commissioner" means the Arkansas Insurance Commissioner;

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

(A) Significant behavioral health needs, including substance abuse treatment and services, and who are eligible for participation in the Medicaid provider-led organized care system as determined by an independent assessment under criteria established by the Department of Human Services; or

(B) Intellectual or developmental disabilities who are eligible for participation in the Medicaid provider-led organized care system as determined by an independent assessment under criteria established by ADHS;

(C) "Covered Medicaid Beneficiary population" does not include individuals enrolled in any long-term services and supports program under 42 U.S.C. § 1396n or 42 U.S.C. § 1315 by reason of a physical functional limitation;

(8) "Department" means the Arkansas Insurance Department;

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

(10) "Enrollable Medicaid beneficiary population" means a group of individuals who are either:

(A) Members of a covered Medicaid beneficiary population; or

(B) Members of a voluntary Medicaid beneficiary population.

(11) "Flexible services" means alternative services that are not included in the state plan or waiver of the Arkansas Medicaid Program and that are appropriate and cost-effective services that improve the health or social determinants of a member of an enrollable Medicaid beneficiary population that affect the health of the member of an enrollable Medicaid beneficiary population;

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

(13) "Medicaid" means the programs authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq., as they existed on January 1, 2017, for the provision of healthcare services to members of enrollable Medicaid beneficiary populations;

(14) "NAIC" means the National Association of Insurance Commissioners;

(15) "Participating provider" means an organization or individual that is a member or has an ownership interest in of a risk-based provider organization and delivers healthcare services to enrollable Medicaid beneficiary populations;

(16) "Quality incentive pool" means a funding source established and maintained by ADHS to be used to reward risk-based provider organizations that meet or exceed specific performance and outcome measures;

(17) "Risk assumption" or "risk sharing" means, for the purpose of this regulation, a transaction whereby the chance of loss, including the expenses for the delivery of service, with respect to the health care of a person, is transferred to or shared with another entity, in return for a consideration. Examples include but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity agreements;

(18) "Risk based capital" means the "RBC level" defined under Ark. Code Ann. § 23-63-1501 (8); and

(19) "Risk-based provider organization" means an entity that:

(A)(i) Is licensed by the Insurance Commissioner under this Rule.

(ii) Notwithstanding any other provision of law, a risk-based provider organization is an insurance company upon licensure by the Commissioner.

(iii) The Commissioner shall not license a risk-based provider organization except as provided under Subchapter 27 — Medicaid Provider-Led Organized Care Act;

(B) Is obligated to assume the financial risk for the delivery of specifically defined healthcare services to an enrollable Medicaid beneficiary population; and

(C) Is paid by ADHS on a capitated basis with a global payment made, whether or not a particular member of an enrollable Medicaid beneficiary population receives services during the period covered by the payment;

(20) "Voluntary Medicaid beneficiary populations" means individuals who are in need of behavioral health services or developmental disabilities services, not otherwise excluded in this subchapter, who are eligible for Medicaid and may elect to enroll in a risk-based provider organization.

Section 5. Certificate of Authority

A. Requirement To Be Newly Formed And Organized.

Unless currently authorized or licensed by the Department as a carrier as defined in Ark. Code Ann. § 20-77-2703(4), no RBPO shall transact business in this State under the Organized Care Act Program unless authorized by a subsisting certificate of authority issued to it by the Commissioner. Unless currently authorized or licensed by the Department as a carrier as defined in Ark. Code Ann. § 20-77-203(4), no RBPO shall be granted a certificate of authority unless it is newly formed and organized for the purpose of its participation in the Organized Care Act Program.

B. Entity Type

The business organization form of an RBPO may be any organization type which permits a valid certificate of authority to be issued to it by the Arkansas

Secretary of State. The RBPO must obtain and maintain a valid certificate of authority issued by the Secretary of State.

Section 6. Certificate of Authority Application

A. Requirements

An RBPO may apply for a certificate of authority on a form prescribed by the Commissioner. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant. If no form application is available by the Arkansas Insurance Department, an RBPO may apply for a certificate of authority in writing to the Commissioner, and, in the request for a certificate of authority, provide the following information:

- (1) The name of the risk-bearing entity (RBPO), the contact information of the RBPO, including business address and phone number of the RBPO. Provide the name, address and contact information for the principal contact person of the RBPO for the Arkansas Insurance Department;
- (2) A list of the names, addresses and official positions of the person who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of the directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association.
- (3) Pay a non-refundable filing fee of two thousand dollars (\$2,000.00) to the Department;
- (4) A detailed summary of its proposed business plan with respect to its proposed plan as an RBPO. This business plan shall include, but not be limited to:
 - a. A description of the services to be provided and the manner in which the RBPO shall provide a network of direct service providers sufficient to ensure that all services to recipients are adequately accessible within time and distance requirements defined by Medicaid;
 - b. A description or plan of the RBPO to ensure that the requirements are met in Ark. Code Ann. § 20-77-2706(f)(2)(A) through (D) and that the RBPO shall timely process claims under Ark. Code Ann. § 20-77-2706(f)(3);
 - c. A description of the projected population or numbers of enrollees or beneficiaries to be serviced on an annual basis by the RBPO;

- d. Describe the network's form of ownership, including the name and the percentage of ownership interest of all members;
- e. A description of the RBPO's capital structure;
- f. A quantitative measurement of its capacity to provide contracted services;
- g. A detailed description of the procedures to be established to provide due process protections for the enrolled Medicaid beneficiary populations (i.e., reconsiderations, grievance procedures, peer review, case utilization procedures, etc.);
- h. A description of the network's geographical service area;
- i. An explanation of the techniques to be implemented to ensure continuity of care or benefits for all enrolled Medicaid beneficiaries should the RBPO incur a change in its providers, geographical area or become financially impaired or insolvent. Explain or describe the extent to which enrolled Medicaid beneficiaries are assured continuity of care by Medicaid in the event of change of its providers, geographical area, or due to the circumstance that the RBPO becomes financially impaired to provide contracted services, substantially equivalent to the requirements in Ark. Code Ann. § 23-76-118.
- j. An explanation of the plan by the RBPO to assure or protect payment to contracted or participating providers of the RBPO, including subcontracted providers in the plan, for services provided should the RBPO become financially insolvent. Such measures and protections may include access to additional capital, stop-loss insurance, business interruption insurance, etc.
- k. A current audit report, if available, certified by an independent certified public accountant, of the applicant's financial condition, or current financial information on a SAP basis, attested to by an officer of the RBPO applicant. In addition, three (3) years of financial projections, including balance sheets, income statements and statements of cash flow must be provided. The financial projections shall contain projected per member per month enrollment at its fiscal year end, and a concise summary of all assumptions used to generate the projections and supported by a statement of an actuarial opinion.
- l. A copy of the RBPO's proposed health coverage plan(s), contracts, arrangements, marketing and advertising material.
- m. A list of the providers comprising the RBPO's provider network, including each provider's medical designation, field of practice or specialty,

licensure or certification category, and a description of the RBPO's procedures for determining, on an on-going basis, that each provider is duly licensed or certified.

n. A list of all entities on whose behalf the RBPO has agreements or contracts to provide health care services under the Organized Care Act Program, including a list of all subcontractors of the RBPO.

o. The parent company's current audited financial statements if the applicant is owned by a parent company.

p. A statement or description identifying sources of additional capital resources that would be available in the event the applicant needs additional capital funding.

(5) Provide biographical backgrounds of all proposed officers, directors, owners and organizers, and information providing confirmation of their background and experience in the management or delivery of the services to be delivered through the RBPO. Such biographical information shall be submitted on the NAIC form, Biographical Affidavit (available upon request). Any person who has managerial involvement or control of a company that underwent any adverse state or federal administrative action shall include information about the adverse administrative action.

(6) Provide a copy of the RBPO's organizational documents (e.g. articles of incorporation, by-laws, partnership agreements, etc.) including any sample contract forms, or generic template contract forms between the RBPO and its participating providers.

(7) Provide a written description evidencing the RBPO ownership or management satisfies the characteristics of an RBPO under Ark. Code Ann. § 20-77-2706 which include:

a. The RBPO holds a valid certificate of authority or instrument of formation issued by the Secretary of State;

b. The RBPO has an ownership interest of not less than fifty-one percent (51%) by participating providers;

c. The RBPO includes within its membership:

(1) One or more of the following Arkansas licensed or certified direct service provider of developmental disabilities services;

(i) Developmental Day Treatment Clinic Services ("DDTCS")

(ii) Private (not state owned and operated) Intermediate Care Facilities for Individuals with Intellectual or Developmental Disabilities (ICF/IDD)

(iii) DDS Waiver Services

(iv) Early Intervention Services (“EI”)

(v) Child Health Management Services (“CHMS”)

(2) One or more of the following Arkansas licensed or certified direct service provider of behavioral health services:

i) Rehabilitation Services for Persons with Mental Illness (“RSPMI”) until June 30, 2018

ii) Outpatient Behavioral Health Agency (“OBHA”)

iii) Licensed Mental Health Practitioner (“LMHP”) until June 30, 2018

iv.) Independently Licensed Practitioner (“ILP”)

(3) An Arkansas licensed hospital or hospital services organization.

(4) An Arkansas licensed physician practice;

(5) A pharmacist who is licensed by the Arkansas State Board of Pharmacy

d. The RBPO has a surety bond in the amount as required under Section Seven (7) of the Organized Care Act.

(8) Provide a copy of any management or administrative contract(s) entered into, or to be entered into, by the RBPO.

(9) Confirm that the RBPO uses standardized codes, billing processes and formats.

(10) Describe how the applicant has the capability to satisfactorily manage the health care coverage issued. This confirmation is to include a detailed description of the RBPO’s procedures established and implemented to ensure the maintenance of all books and records necessary to meet all reporting requirements. This requirement can be met through a third party management or administration agreement.

(11) Describe the RBPOs global payment amount awarded, or, if not available, the estimated or projected global payment amount or rates. Describe the actual or projected monthly payments or monthly reimbursement amounts under the global payment to the RBPO by Medicaid. Provide a copy of all contracts between the RBPO and Medicaid related to the RBPOs participation in the Organized Care Act program.

(12) Describe the RBPOs rates or charges to participating providers. This information shall include the basis for the calculation of the rate or charge (e.g., use of usual, customary, and reasonable (UCR) rates).

(13) Describe any and all stop-loss arrangements or reinsurance arrangements of the RBPO for participation in this program.

(14) A copy of the basic organizational document of the RBPO, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents, and all amendments thereto; a copy of the bylaws, rules and regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant.

(15) A copy of any contract made or to be made between any providers and the applicant or persons under Section Seven (7)(A)(4)(M) of this Rule.

(16) Any other information deemed necessary by the commissioner in evaluating the application.

B. Material Changes.

Prior to implementing any material changes in its operations or in the coverage offered by the RBPO, the RBPO must submit to the Commissioner a written description of any material modification to its plan of operation, or a written explanation of any material changes to the information submitted in accordance with this Section. If the Commissioner does not disapprove within sixty (60) days of filing, the modification shall be deemed approved.

Section 7. Solvency Standards

All RBPOs shall be responsible for meeting the following solvency standards under this Section at the time of initial licensure, in the evaluation of their application, and continuously thereafter. All RBPOs acting as a carrier under Ark. Code Ann. § 20-77-2703(4) shall be subject to this Section in addition to any other provision in the Arkansas Insurance Code or Rules applicable to its type of

organization, unless excluded by this Rule or the Organized Care Act or by Medicaid pre-emption.

A. Solvency Standards

All RBPOs participating in the Organized Care Act program shall:

(1) meet the reserve or capital requirements under Ark. Code Ann. § 20-77-2706(f)(4) and any additional amounts needed to satisfy Risk-Based Capital Requirements under Ark. Code Ann. § 23-63-1501 et seq. (hereafter, “HMO-RBC”). The reserve requirements in Ark. Code Ann. § 20-77-2706(f)(4) shall refer to the organization’s capital or capital and surplus under Statutory Accounting Principles (SAP). The Commissioner may adjust the reserve requirements of the RBPO from initial licensure, on a prospective basis, related to the timing of the RBPO assumption levels of partial to full risk in its business operations. In addition, the Commissioner may consider the extent to which the RBPO has reinsurance or stop loss coverage, or agreements with a licensed insurer or HMO, to cede risk, as a circumstance to reduce or modify reserve or capital requirements under this Section. The Commissioner shall review and approve all such risk sharing agreements including any major modifications thereof.

(2) comply with SAP reporting and file quarterly and annual financial statements with the Department under SAP in the same manner as is required of a health maintenance organization regulated by the Department under Ark. Code Ann. § 23-76-113;

(3) comply with HMO-RBC requirements and reporting;

(4) comply with Ark. Code Ann. § 23-63-601 et seq., referring to assets and liabilities;

(5) comply with Ark. Code Ann. § 23-68-101 et seq., referring to rehabilitation and liquidation;

(6) comply with Ark. Code Ann. § 23-69-134, referring to home office and records and the penalty for unlawful removal of records;

(7) comply with Ark. Code Ann. § 23-76-122 related to examinations, in the same manner as a health maintenance organization;

(8) comply with Sections Ark. Code Ann. §§ 23-60-101 through 23-60-108 and 23-60-110 referring to the scope of the Arkansas Insurance Code;

- (9) comply with Sections Ark. Code Ann. §§ 23-61-101, 23-61-201, 23-61-301 referring to the Insurance Commissioner;
- (10) comply with Section Ark. Code Ann. §§ 23-63-102 through 23-63-104, 23-63-201, et seq., general provisions, and 23-63-301 et seq., referring to service of process, a registered agent as process agent, serving legal process, and time to plead;
- (11) comply with the annual independent audit under Ark. Code Ann. § 23-63-216(a)(5) and actuarial requirements under Ark. Code Ann. § 23-63-216(e)(1) and (e)(2);
- (12) comply with the custody of assets requirements under Ark. Code Ann. § 23-69-134; and
- (13) comply with the transfer of ownership requirements or acquisition provisions under Ark. Code Ann. § 23-69-142.

Section 8. Market Conduct Related Activities and Network Adequacy

A. RBPO Provider Market Conduct Activities

The Insurance Commissioner is primarily authorized to regulate the financial solvency and licensing of the RBPO under the Organized Care Act. The Insurance Commissioner shall not administratively adjudicate, review, process complaints, enforce or apply provisions of the Arkansas Insurance Code, Rules, Bulletins or Directives upon an RBPO, or contracted third party administrator, if applicable, related to claims payment disputes, claims payment delays, provider payment rate(s), provider credentialing, provider reimbursement programs, network related procedures or filing requirements, if such arise during the course of Organized Care Act Program, unless the complaint or concern relates to “Any Willing Provider” access (Ark. Code Ann. §§ 23-99-201, et seq., 23-99-801 et seq.), or significantly reflects upon the financial condition of the RBPO. Complaints or inquiries about claims payment delays or requirements shall be referred to ADHS.

RBPO Network Adequacy Requirements

ADHS shall be responsible for certifying, approving and monitoring whether an RBPO meets the required network access or network adequacy for services under the Organized Care Act. The Commissioner however shall review network

adequacy of the RBPO at licensure, or upon renewal of licensure, but shall accept certification from ADHS that the RBPO has sufficient network adequacy as required under the Organized Care Act.

Section 9. Confidentiality & Workpapers

The confidentiality provisions in the Arkansas Insurance Code and Rules, including but not limited to Ark. Code Ann. § 23-61-103(d)(5), related to actuarial reports, Ark. Code Ann. § 23-61-103(d), related to active investigations or examinations, Ark. Code Ann. § 23-61-107, related to financial records and Ark. Code Ann. § 23-61-207, related to ancillary information and workpapers, shall apply in the same manner to an RBPO as are applied to a health insurer or health maintenance organization.

Section 10. Payment of Premium Taxes

Pursuant to Ark. Code Ann. § 26-57-603, a RBPO that is licensed under the Organized Care Act and participates in the Medicaid provider-led organized care system offered by the Arkansas Medicaid Program for enrollable Medicaid beneficiary populations as defined in § 20-77-2703 shall pay to the Treasurer of State through the Commissioner a tax imposed for the privilege of transacting business in this state.

(2) The tax shall be computed at a rate of two and one-half percent (2½%) on the total amount of funds received in global payments to a risk-based provider organization participating in the Medicaid provider-led organized care system.

(3) The tax shall be:

(A) Reported at such times and in such form and context as prescribed by the commissioner; and

(B) Paid on a quarterly basis as prescribed by the Commissioner.

Section 11. Effective Date

This Rule shall be effective on and after September 25, 2017.



ALLEN W. KERR
INSURANCE COMMISSIONER

9-15-17

DATE