Stricken language would be deleted from and underlined language would be added to present law.

State of Arkansas
89th General Assembly
Regular Session, 2013

A Bill

SENATE BILL 886

By: Senator Bledsoe

For An Act To Be Entitled

AN ACT TO PROVIDE TRANSPARENCY IN THE DEVELOPMENT AND IMPLEMENTATION OF HEALTHCARE PAYMENT AND DELIVERY REFORM; AND FOR OTHER PURPOSES.

Subtitle

TO ESTABLISH THE HEALTHCARE REFORM TRANSPARENCY ACT.

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

SECTION 1. Arkansas Code Title 23, Chapter 99, is amended to add an additional suchapter to read as follows:

Subchapter 9 — Healthcare Reform Transparency Act

23-99-901. Title.

This subchapter shall be known and may be cited as the "Healthcare Reform Transparency Act".

23-99-902. Legislative findings and intent.

(a) The General Assembly finds that:

(1) Healthcare payment and delivery reform will have a significant impact on the state's residents, employers, and providers of healthcare services;

(2) Negative impacts of healthcare payment and delivery reform can be minimized through advance public notice of changes;

(3) Information documenting the results of healthcare payment and delivery reform is an important consideration in developing and implementing future reforms; and

(4) Regular reporting of the results of healthcare payment and delivery reform enhances the ability of patients, employers, and providers to make informed decisions regarding their healthcare options and the ability of state policy makers to govern the implementation of reform.

(b) The General Assembly intends for this subchapter to promote transparency in the development and implementation of healthcare payment and delivery reform by public and private payors in this state.

23-99-903. Definitions.

As used in this subchapter:

(1) "Covered individual" means an individual whose medical care costs are paid or reimbursed, in whole or in part, by a payor;

(2) "Gain-sharing payments" means an increase in payments or additional payments made by payors to providers as a result of meeting or exceeding cost thresholds or quality standards;

(3)(A) "Healthcare payment and delivery reform" means changes in the manner in which providers or covered individuals are paid for healthcare goods or services delivered to a payor's covered individuals, including without limitation:

(i) Payments based on payor-defined episodes of care for specific diagnoses, conditions, or procedures;

(ii) Payments to providers for acting as a medical home or a health home for a covered individual generally or a specific subset of covered individuals;

(iii) Bundled payments to a provider in which a provider that receives the payments is expected to pay another provider that provides services to a covered individual for a specific diagnosis, condition, or procedure;

(iv) Gain-sharing payments;

(v) Risk-sharing payments;

(vi) A payment to an individual or entity that is not a provider for goods or services related to healthcare services provided by providers;

(vii) A change in the amount required to be paid by a covered individual for healthcare goods or services or a change in the process by which the amount required to be paid by a covered individual for

healthcare goods or services amount is determined if the change is for the purpose of encouraging changes in the volume or type of healthcare goods and services received by a covered individual; and

(viii) Coverage of an individual who is eligible for Medicaid expansion under Section 2001 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

(B) "Healthcare payment and delivery reform" does not include:

(i) A routine change in a fee schedule;

(ii) A contracted payment rate to a provider;

(iii) A change in capitation payments; or

(iv) A change in the amount required to be paid by a covered individual if the change is not a component of a larger initiative to improve the quality of healthcare goods or services or to change the protocols or systems by which healthcare goods or services are delivered;

(4) "Payor" means an entity, including without limitation:

(A) An insurance company;

(B) A hospital and medical service corporation;

(C) A physician hospital organization; and

(D) A state entity operating a medical assistance program under Title XIX of the Social Security Act 42 U.S.C. § 1396 et seq., or Title XXI of the Social Security Act 42 U.S.C. § 1397 et seq., that administers, offers, or provides payment for healthcare goods or services provided to specific individuals who are enrolled in that entity's plan;

(5) "Provider" means an individual or entity that is eligible to receive payments from a payor for healthcare goods or services delivered to a covered individual; and

(6) "Risk-sharing payments" means a reduction in payments to, recoupment of payments from, or repayment of payments received by a provider as a result of the provider's not meeting cost thresholds or quality standards.

23-99-904. Quarterly reports.

(a) Each payor doing business in the State of Arkansas shall provide quarterly reports to the Chair of the Senate Committee on Public Health, Welfare, and Labor and the Chair of the House Committee on Public Health,

Welfare, and Labor.

(b) Each report shall cover one (1) calendar quarter and shall be submitted by the last day of the month following the end of the calendar quarter.

(c) Each quarterly report shall include the following information, as applicable:

(1) A description of each healthcare payment and delivery reform initiative currently implemented by that payor that has not previously been described in a quarterly report, describing the payment and service delivery features of the initiative and the structure of the reform, including without limitation, as applicable:

(A) Cost thresholds or quality standards that are tracked as part of the reform;

(B) The methodology for calculation of gain-sharing payments or risk-sharing payments;

(C) The methodology for determining that a provider is eligible for gain-sharing payments or risk-sharing payments;

(D) A component of the reform that changes the amounts paid by a covered individual to influence the volume or type of healthcare goods and services received;

(E) A component of the healthcare payment and delivery reform initiative intended to increase covered individuals' compliance with appointments, care protocols, or other recommendations by providers or care managers designed to improve the health of the covered individuals;

(F) Criteria by which covered individuals or providers are excluded from the healthcare payment and delivery reform or from the determination of gain-sharing payments or risk-sharing payments or the measurement of quality standards under the healthcare payment and delivery reform;

(G) Criteria by which patient-specific services or patient-specific episodes of care that otherwise meet the definition of covered services or episodes of care are excluded from the healthcare and delivery reform or from the determination of gain-sharing payments or risk-sharing payments or the measurement of quality standards under the healthcare payment and delivery reform; and

(H) A limitation on gain-sharing payments or risk-sharing

payments;

(2) A change in or an addition to information provided in a previous report under subdivision (c)(1) of this section;

(3) A description of a new healthcare payment and delivery reform or new component of an existing healthcare payment and delivery reform scheduled for implementation during the upcoming quarter, including, as applicable, the information required under subdivision (c)(1) of this section; and

(4) Results of the healthcare payment and delivery reform for the quarter and year-to-date, including without limitation, as applicable:

(A) Savings in healthcare costs;

(B) A change in a measure of quality of care received by a covered individual;

(C) The number of providers by provider type and specialty and by component receiving gain-sharing payments under the healthcare payment and delivery reform;

(D) The number of providers by provider type and specialty and by component subject to risk-sharing payments under the healthcare payment and delivery reform;

(E) A change in the number of providers by provider type, participating in the healthcare payment and delivery reform;

(F) A general description of complaints received from providers or covered individuals regarding the healthcare payment and delivery reform;

(G) The results of a patient engagement effort such as those described in subdivisions (c)(1)(D) and (E) of this section; and

(H) The costs paid by the payor for outside contracts for services relating to designing, implementing, or monitoring the healthcare payment and delivery reform.

(d) A payor doing business in the State of Arkansas that is not implementing a healthcare payment and delivery reform is not required to file a quarterly report under this section.