SECTION 1. Arkansas Code Title 20, Subchapter 77 is amended to add a new subchapter as to read as follows:

SECTION 2. **§ 20-77-2801. Title**

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

SECTION 3. **§ 20-77-2802. Purpose and legislative intent.**

(a) As the single state agency for administration of the medical assistance programs established under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XIX of the Social Security Act, 42 U.S.C. § 1397aa et seq., the Department of Human Services is authorized by federal law to utilize one (1) or more organizations to administer and arrange for the provision of medically-necessary goods and services to Medicaid beneficiaries.

(b) The purpose of this subchapter is to establish a system of provider-led organized care in which health care and other services for specified populations of Medicaid beneficiaries are paid, administered, and delivered through one or more risk bearing organizations.

(c) It is the intent of the General Assembly that the system of provider-led organized care should:

(A) Improve the experience of care, including quality, access, and reliability, for the Medicaid beneficiary populations subject to the delivery system created herein;

(B) Enhance the performance of the broader health system, leading to improved overall population health;

(C) Slow or reverse spending growth for the covered populations and services while improving quality and access to care;

(D) Further the objectives of Arkansas payment reform and the State's ongoing commitment to innovation, efficiency, quality and access to services;

(E) Discourage inappropriate utilization of medical services;

(F) Reduce waste, fraud, and abuse; and

(G) Encourage the most efficient use of taxpayer funds.

SECTION 4. **§ 20-77-2803. Definitions.**

(1) "Care coordination" means services delivered by health provider teams to empower patients in their health and health care, and improve the efficiency and effectiveness of the health sector and may include, but are not limited to:

(i) Health education and coaching;

(ii) Navigation of the medical home services and the health care system at large;

(iii) Coordination of care with other providers including diagnostics and hospital services;

(iv) Support with the social determinants of health such as access to healthy food and exercise;

(v) Activities focused on the patient and communities' health including outreach, quality improvement and patient panel management.

(2) "Carrier" means an organization that is licensed or otherwise authorized to transact accident and health insurance or to transact as a health maintenance organization under 23-76-102 (9), or a hospital medical service corporation under 23-75-101.

(3) “Commissioner” means the commissioner of the Arkansas Insurance Department;

(4) “Covered Medicaid beneficiary population” means the populations of Medicaid beneficiaries defined at §20-77-2804.

(5) “Department” means the Department of Human Services;

(6) “Direct Service Provider” means an organization or individual involved in the delivery of flexible services or healthcare goods and services to the covered Medicaid beneficiary populations;

(7) “Flexible Services” means services a Medicaid beneficiary within the covered population may need that are not reimbursed by Medicaid, including but not limited to:

(A) Costs associated with transitioning from an institutional setting to a community setting;

(B) Maintenance of a dwelling to ensure health and safety and to prevent disruption of a community setting or institutionalization;

(C) Securing payment of property taxes to prevent the loss of a home;

(D) Food, home-delivered meals, or nutritional supplements.

(8) “Global payment” means a population-based payment methodology that is based on an all inclusive, per-member per-month calculation for all benefits, administration, care management and care coordination for covered Medicaid beneficiary populations.

(9) “Medicaid” means the programs authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XIX of the Social Security Act, 42 U.S.C. § 1397aa et seq., for the provision of medical goods and services to qualified beneficiaries.

(10) "Participating Provider" means an organization or individual that is a member of a Risk-Based Provider Organization and is involved in the delivery of flexible services or healthcare goods and services to the covered Medicaid beneficiary populations;

(11) "Associated participant" means an individual or organization brought into a Risk-Based Provider Organization, either as a member or as a contractor, to provide one or more of the necessary administrative functions, including but not limited to claims processing, data collection and outcome reporting.

(12) "Quality Incentive Pool" means a funding source established and maintained by the department to be used to reward Risk-Based Provider Organizations that meet or exceed specific performance and outcome measures;

(13) "Risk-Based Provider Organization" means an entity that is:

(A) Authorized under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396m and 1396n(b) of Title XIX of the Social Security Act, and meets the requirements of 42 C.F.R. §§ 431, 433, and 438 et al.

(B)(1) Certified by the Arkansas Insurance Department under rules and regulations established for such entities by the commissioner;

(2) Notwithstanding any other provision of law, a Risk-Based Provider Organization is deemed an insurance company upon obtaining certification by the commissioner.

(C) Obligated to assume the financial risk for the delivery of specifically defined medically-necessary goods and services and flexible services to a defined population or populations of Medicaid beneficiaries,

and;

(D) Paid by the insurance department on a capitated basis, with payment made regardless of whether a particular beneficiary receives services during the period covered by the payment.

(E) The commissioner may not certify a Risk-Based Provider Organization except as authorized in this subchapter.

SECTION 5. **§ 20-77-2804. Populations covered by provider-led organized care.**

(a) The commissioner may certify one (1) or more Medicaid Risk-Based Provider Organizations that satisfactorily meet certification requirements and are capable of coordinating the provision and payment of medical, health care, and flexible services for the following Medicaid beneficiary populations:

(1) Individuals with significant behavioral health needs and who are eligible for participation in the provider-led organized care system as determined by an independent assessment under criteria established by the department;

(2)(A) Individuals with an intellectual or developmental disability who are eligible for participation in the provider-led organized care system due to being categorized as Tier II or Tier III as determined by an independent assessment under criteria established by the department;

(B) The comprehensive risk shall exclude those individuals who qualify for and reside in a human development center operated by the department.

(C) The department may adopt rules to include additional populations, including individuals who are aged, blind, or physically disabled and are determined eligible to participate in the provider-led organized care system as determined by an independent assessment;

(b) The commissioner shall require a Medicaid Risk-Based Provider Organization to enroll qualified Medicaid beneficiaries statewide.

SECTION 6. **§ 20-77-2805. Excluded services.**

(a) With the exception of those described in subsection (b), all services delivered through the provider-led organized care system will be available for Medicaid recipients within the covered populations and shall not be less in amount, duration and scope, than those available to other Medicaid eligible individuals, as specified in the state plan for medical assistance.

(b) The provider-led organized care system implemented pursuant to this subchapter shall be implemented to the extent possible, but shall not include the following services when provided to covered Medicaid beneficiary populations:

(1) Nonemergency medical transportation in a capitated program;

(2) Dental benefits in a capitated program;

(3) School Based Services provided by school employees;

(4) Skilled nursing facility services;

(5) Assisted living facility services; and

(6) Human Development Center services.

SECTION 7. **20-77-2806. Characteristics and duties of Risk-Based Provider Organizations.**

(a) A Risk-Based Provider Organization must be authorized to conduct business in the state and hold a valid certificate of authority issued by the Secretary of State and:

(1) have ownership interest of not less than fifty-one percent (51%) by participating providers;

(2) include within its membership:

(A) a licensed or certified direct service provider of developmental disabilities services;

(B) a licensed or certified direct service provider of behavioral health services;

(C) a hospital or hospital services organization;

(D) a physician practice;

(E) a pharmacist or pharmacy benefit organization.

(b) A Risk-Based Provider Organization that meets the requirements of section (a) (1) and (2) may include within its membership a carrier, administrative entity, federally qualified health clinic, rural health clinic, associated participant, or any other type of direct service provider that delivers or is qualified to deliver health care goods or services to the covered Medicaid beneficiary populations necessary to allow for access to and coordination with medical, mental health and substance abuse service providers, and to facilitate access to flexible services and other community and support services.

(c)(1) A Medicaid Risk-Based Provider Organization may provide health care and medical goods and services directly to beneficiaries, or through:

(2) a direct service provider that is a participating provider in the Risk-Based Provider Organizations;

(3) a direct service provider subcontracted by the Risk-Based Provider Organization; or

(4) an independent provider that enters into a provider agreement or business relationship with a direct service provider.

(d) Reimbursement rates paid by a Risk-Based Provider Organization to direct service providers shall:

(1) be determined by mutual agreement of the Risk-Based Provider Organization and direct service provider without regard to Medicaid provider rates established by the department or by state law.

(2) assure efficiency, economy, quality, and equal access to the covered populations in the same manner as populations served outside of Medicaid.

(f) The rates established by a Risk-Based Provider Organization shall not be subject to any administrative review by the Commissioner;

(g) Policies and procedures established by a Risk-Based Provider Organization relating to the provision of goods and services by a direct service provider shall:

(1) be determined by mutual agreement of the Risk-Based Provider Organization and provider without regard to Medicaid provider rates established by the department or by state law;

(2) assure efficiency, economy, quality, and equal access to the covered populations in the same manner as populations served outside of Medicaid;

(h) Any direct service provider delivering services to the covered Medicaid beneficiary populations shall meet any licensing or certification requirements set by law or regulation, shall be enrolled as a Medicaid provider, and shall not otherwise be disqualified from participating in Medicare or Medicaid.

(i) Upon certification by the commissioner, a qualifying Risk-Based Provider Organization must be capable of performing the following functions:

(1) Enrollment and disenrollment of members within the covered Medicaid beneficiary populations into the Risk-Based Provider Organization;

(2) Ensuring protection of beneficiary rights and due process;

(3) Processing claims or otherwise ensuring payment to direct service providers within time frames established under federal regulations for goods and services delivered to the covered Medicaid beneficiary populations;

(4) Maintaining a network of direct service providers sufficient to ensure that all services to recipients are adequately accessible within time and distance requirements defined by the state;

(5) Complying with all data collection and reporting requirements established by the commissioner;

(6) Providing financial reports and information to the commissioner as required by § 26-57-603;

(7) Providing practice and clinical support to direct service providers;

(8) Ensuring proper credentialing of direct service providers in accordance with state and federal requirements;

(9) Ensuring care coordination of members enrolled into the Risk-Based Provider Organization;

(10)(A) Managing global capitated payments and the attendant financial risks for delivery of services to the covered Medicaid beneficiary populations;

(B) The Department of Human Services shall develop capitated rates for a defined scope of services under a risk methodology that includes risk adjustments, reinsurance, or stop-loss funding methods.

(11) Maintaining restricted reserves of not less than $6,000,000, or another amount as determined by rules and regulations of the Arkansas Insurance Department, as well as maintaining minimum capital or surplus in the amount of $750,000.

(12)(A) Managing incentive payments received from the quality incentive pool when quality and outcome measures are achieved;

(B) The Department of Human Services may develop rules establishing criteria for quality incentive payments to encourage and reward delivery of high quality care and services by a Risk-Based Provider Organization.

SECTION 8. **§ 20-77-2807. Reporting and Performance Measures**.

(a)(1) Each certified Medicaid RBPO shall submit to the department on a quarterly basis protected health information for each Medicaid beneficiary enrolled with the Risk-Based Provider Organization, including without limitation claims data, encounter data, unique identifiers, and geographic and demographic information, in accordance with standards and procedures adopted by the department.

(2) Personally-identifiable data submitted under this section shall be treated as confidential and are exempt from disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq.

(b) The department shall utilize submitted data to measure the organization's performance in the delivery of services, patient outcomes, efficiencies achieved, and quality measures.

(c) Performance measures established by the department shall at a minimum monitor:

(1) Reductions in unnecessary hospital emergency department utilization;

(2) Adherence to prescribed medication regimens;

(3) Reductions in avoidable hospitalizations for ambulatory sensitive conditions;

(4) Reduction in hospital readmissions.

(d) The department shall issue funds from the quality incentive pool above the amount of the total global payments initially provided to a Risk-Based Provider Organization that meets or exceed specific performance and outcome measures established by the department.

(e) On an annual basis, the department shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding:

(1) RBPO membership enrollment and distribution;

(2) Patient experience data; and

(3) Financial performance, including demonstrated savings.

SECTION 9. **§ 20-77-2808. Waiver authority -- rulemaking authority.**

(a) The department shall submit application for any federal waivers, federal authority, or Medicaid State Plan Amendments necessary to implement this subchapter.

(b) The department may promulgate rules in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq. as necessary to carry out this subchapter.

SECTION 10. **§ 20-77-2809. Implementation of provider-led organized care system.**

(a) The Medicaid provider led organized care system shall be implemented according to the following timeline:

(1) Not later than June 1, 2017, the commissioner shall adopt rules for the certification of Risk-Based Provider Organizations to implement this chapter.

(2)(A) Not later than July 1, 2017, an organization seeking conditional certification in state fiscal year 2018 to become a Risk-Based Provider Organization shall submit an application to the commissioner.

(B) An organization may receive conditional certification as a Risk-Based Provider Organization upon demonstration of a governing board and sufficient agreements with various providers of medical goods and services.

(C) A certification issued conditionally shall expire on December 31, 2017, or a later date as established by the commissioner.

(3) Not later than October 1, 2017, an organization with conditional certification shall:

(A) Be capable of enrolling members of covered Medicaid beneficiary populations into the Risk-Based Provider Organization;

(B) Demonstrate to the commissioner's approval the ability to establish an adequate medical service delivery network.

(C) Provide evidence of a bond issued by a surety authorized to do business in this state in the amount of $ 250,000.

(D) The bond shall provide that the surety and the organization shall be jointly and severally liable for payment of the bond amount in the event the organization abandons efforts to obtain full certification.

(E) Any payouts on a bond issued pursuant to this section shall be paid to the Medicaid Trust Fund established at § 19-5-985.

(4) Not later than January 1, 2018, an organization with conditional certification shall demonstrate to the commissioner that it has met the solvency and financial requirements for a Risk-Based Provider Organization as established by the commissioner.

(5) No later than, April 1, 2018, or a later date established by the commissioner, an organization with conditional certification shall demonstrate to the commissioner that it is capable of assuming the risk of a global payment and arranging for provision of medically-necessary goods and services to the covered Medicaid beneficiary populations.

(b)(1) Failure to comply with any one of the milestones in subdivisions (2) to (5) shall be grounds for termination of a conditional certification or full certification.

(2) The commissioner shall award full certification to a Risk-Based Provider organization with conditional certification if the organization timely meets each of those benchmarks.

(3) Failure by an organization to timely meet one or more of the milestones in subdivisions (2) to (5) shall not prevent the commissioner, in his or her sole discretion, from granting full certification to the organization as long as it has met all of those benchmarks by January 1, 2018, or a later date established by the commissioner.

(c) Implementation of the provider-led care coordination system shall not be considered a rule under the Arkansas Administrative Procedure Act, Arkansas Code § 25-15-201 et seq.

Section 11. Arkansas Code §19-5-985, concerning the Arkansas Medicaid Program Trust Fund, is amended to read as follows:

(a) There is hereby established on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a fund to be known as the Arkansas Medicaid Program Trust Fund.

(b)(1) The fund shall consist of the following:

(A) All revenues derived from taxes levied on soft drinks sold or offered for sale in Arkansas under the Arkansas Soft Drink Tax Act, § 26-57-901 et seq., there to be used

exclusively for the state match of federal funds participation under the Arkansas Medicaid Program;

(B) The additional ambulance annual fees stated in § 20-13-212;

(C) Payments from surety bonds issued pursuant to § 20-77-2809;

~~(C)~~ (D) The special revenues specified in §§ 19-6-301(156) and 19-6-301(236); and

~~(D)~~ (E) The amounts collected under §§ 26-57-603(f), 26-57-604 and 26-57-605 above the forecasted level for insurance premium taxes set by the Chief Fiscal Officer of the State under § 10-3-1404(a)(1)(A).

(2) If the Arkansas Medicaid Program should be discontinued for any reason, the revenues derived from the soft drink tax levied in the Arkansas Soft Drink Tax Act, § 26-57-901 et seq., shall be used exclusively to provide services to Arkansas residents comparable to the services now provided under the Arkansas Medicaid Program.

SECTION 12. Arkansas Code Title 23, Chapter 61, is amended to add an additional subchapter to read as follows:

Subchapter 1100. Risk-Based Provider Organizations.

23-61-1100. Risk-Based Provider Organizations.

(a) The Arkansas Insurance commissioner shall regulate the licensing and financial solvency of Risk-Based Provider Organizations participating in provider-led organized care programs by the Arkansas Medicaid program for specified populations of Medicaid beneficiaries.

(b) The Arkansas Insurance commissioner is authorized to issue rules to regulate the licensing and solvency of Risk-Based Provider Organizations participating in provider-led organized care programs by the Arkansas Medicaid program for covered populations of Medicaid beneficiaries.

(c) The Arkansas Insurance commissioner is authorized to impose and collect a reasonable fee from a Risk-Based Provider Organization for the regulation and licensing of the organization as established by rule of the Arkansas Insurance Department.

(d) The Arkansas Insurance commissioner is further authorized to administer collection of the annual tax imposed on Risk-Based Provider Organizations as defined under Arkansas Code § 26-57-603 pursuant to a rule issued by the Arkansas Insurance Department. The commissioner shall describe the reporting, forms and requirements related to the payment of the annual tax in a rule issued by the Arkansas Insurance Department.

SECTION 13. Arkansas Code § 26-57-603, concerning insurance premium taxes, is amended to add an additional subsection to read as follows:

(f) Each Risk-Based Provider Organization that is licensed pursuant to § 23-61-1100 and participates in a provider-led organized care program by the Arkansas Medicaid program specified populations of Medicaid beneficiaries shall pay to the State Treasurer through the commissioner an annual tax imposed for the privilege of transacting business in this state. This tax shall be computed at a rate of two and one-half percent (2 1/2 %) on the total amount of funds received from the organization from certification awarded to an organization participating

in the provider-led organized care program. This tax shall be paid on an annual basis and reported at such time and in such form and context as prescribed by the commissioner by rule.

SECTION 14. Arkansas Code § 26-57-603, concerning credits of insurance premium taxes, is amended to add an additional subsection to read as follows:

§ 26-57-604. Remittance of tax--Credit

(a)(1)(A) Coincident with the filing of the tax report, each authorized life or accident and health insurer, including licensed health maintenance organizations, may apply for a credit for the noncommissioned salaries and wages of the insurer's Arkansas employees that are paid in connection with its insurance operations.

(B)(i) The credit may be applied as an offset against the premium tax imposed in § 26-57-603(d) on life and accident and health insurance.

(ii) However, the credit shall not be applied as an offset against the premium tax on collections resulting from an eligible individual insured under the Health Care Independence Act of 2013, § 20-77-2401 et seq., the Arkansas Works Act of 2016, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003.

(iii) The credit shall not be applied against the premium tax on collections resulting from global payments made to a Risk-Based Provider Organization as established at § 20-77-2086.

(2)(A) In no event shall the offset reduce the accident and health premium tax due by more than eighty percent (80%).

(B) In no event shall the offset reduce the life premium tax due by more than seventy percent (70%).

(C) The taxes shall be reported and paid on a quarterly estimated basis as prescribed by the Insurance Commissioner and shall be reconciled annually at the time of filing the annual report required in § 26-57-603(a)-(c).

(3) An employee shall be employed for six (6) months for the salary or wages to be eligible to qualify for the life or accident and health premium tax credit.

(4)(A)(i) Except as provided in subdivision (a)(4)(B) of this section, on or before March 1 of each year, any such authorized life or accident and health insurer, including health maintenance organizations, desiring to qualify under this provision shall furnish the appropriate data and request on forms prescribed by the commissioner.

(ii) For purposes of calculating the taxes under §§ 23-63-102--23-63-104, an insurer qualifying for a credit under this section shall compute the tax due under §§ 23-63-102--23-63-104, if any, by using an Arkansas premium tax rate of two and one-half percent (2 ½ %).

(B)(i) Subdivision (a)(4)(A) of this section shall only apply for tax years beginning prior to January 1, 2000.

(ii) By March 1 of each year, an authorized life or accident and health insurer, including health maintenance organizations, desiring to qualify under this provision shall furnish the appropriate data and request on forms prescribed by the commissioner.

(iii) However, for purposes of calculating the taxes under §§ 23-63-102--23-63-104, an insurer qualifying for a credit under this section shall compute the tax due under §§ 23-63-102--23-63-104, if any, by using an Arkansas premium tax rate of two and one-half percent (2 ½ %) without regard to the credit specified in this section.

(b)(1) Each insurer other than those in § 26-57-603(d) and subsection (a) of this section shall pay to the Treasurer of State through the commissioner, as a tax imposed for the privilege of transacting business in this state, a tax at the rate of two and one-half percent (2 ½ %) upon the net premiums and net considerations on all kinds of insurance, except as provided in § 26-57-605.

(2) The taxes shall be paid on a quarterly estimate basis as prescribed by the commissioner and shall be reconciled annually at the time of filing the annual report required in § 26-57-603(a)-(c).

(c)(1) In addition to any premium tax credit not related to the same eligible property for which an insurer qualifies under subsection (a) of this section, there is allowed a premium tax credit for the amount of the Arkansas historic rehabilitation income tax credit allowed by the certification of completion issued by the Department of Arkansas Heritage under the Arkansas Historic Rehabilitation Income Tax Credit Act, § 26-51-2201 et seq.

(2) The premium tax credit under this subsection may be used to offset the premium tax imposed by §§ 26-57-603 -- 26-57-605.

(3) The amount of the premium tax credit under this section that may be claimed by the taxpayer in a tax year shall not exceed the amount of premium tax due by the taxpayer.

(4) Any unused premium tax credit may be carried forward for a maximum of five (5) consecutive taxable years for credit against the premium tax.

(5) The commissioner shall promulgate rules to implement this section.

SECTION 15. Arkansas Code § 26-57-610, concerning disposition of insurance premium taxes, is amended to add an additional subsection to read as follows:

§ 26-57-610. Disposition of taxes

(a) The Insurance Commissioner shall deposit all taxes collected under §§ 26-57-604 and 26-57-605 into the State Treasury.

(b) On the last business day of each month the Treasurer of State shall classify the taxes by type of revenue and credit the net amounts respectively of taxes collected under §§ 26-57-604 and 26-57-605 as follows:

(1) The taxes based on premiums collected as special revenues shall be distributed to the respective cities, incorporated towns, and fire protection districts in this state for credit to the respective firemen's relief and pension funds;

(2) The taxes based on premiums collected under the Health Care Independence Act of 2013, § 20-77-2401 et seq., the Arkansas Works Act of 2016, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003 shall be:

(A) At the time of deposit, separately certified by the commissioner to the Treasurer of State for classification and distribution under this section; and

(B)(i) On or before December 31, 2016, transferred to the Health Care Independence Program Trust Fund and used as provided by § 19-5-1141.

(ii) On and after January 1, 2017, transferred to the Arkansas Works Program Trust Fund and used as required by the Arkansas Works Program Trust Fund;

(3) The taxes based on premiums collected under the Provider-led Organized Care Act of 2017, § 20-77-2801 et seq. shall be:

(a) At the time of deposit, separately certified by the commissioner to the Treasurer of State for classification and distribution under this section; and

bB) Transferred to the Arkansas Medicaid Program Trust Fund and used as provided by § 19-5-985.

(c) Used in whole or in part to provide funding for:

(ii) home and community based services to individuals with intellectual and developmental disabilities;

(ii) the quality incentive pool defines at § § 20-77-2803 (12);

(iii) other services covered by the Medicaid program as determined by the department.

SECTION 16. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that a system of provider-led organized care to improve the experience of health care, including quality, access, and reliability, for the covered Medicaid beneficiary populations will enhance the performance of the broader health system, lead to improved overall population health, slow or reverse spending growth for services delivered to the covered populations of Medicaid beneficiaries while improving quality and access to care.

Furthermore, the State's ongoing commitment to innovation, efficiency, quality and access to services will discourage inappropriate utilization of medical services, reduce waste, fraud, and abuse; and encourage the most efficient use of taxpayer funds.

Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.