

2014 SPECIAL SESSION I

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SENATE BILL NO. 5006

Offered September 18, 2014

A *BILL to amend the Code of Virginia by adding in Title 32.1 a chapter numbered 17, consisting of sections numbered 32.1-370 through 32.1-382, relating to the delivery of health care services to Medicaid beneficiaries through regional care organizations.*

Patron—Stanley

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 32.1 a chapter numbered 17, consisting of sections numbered 32.1-370 through 32.1-382, as follows:

CHAPTER 17.

MEDICAID REGIONAL CARE ORGANIZATIONS.

§ 32.1-370. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Alternate care provider" means a contractor, other than a regional care organization, that agrees to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the Commonwealth pursuant to a risk contract.

"Capitation payment" means a payment that the Department makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services.

"Care delivery system" means the manner in which the benefits and services set forth in the state Medicaid plan are provided to Medicaid beneficiaries.

"Collaborator" means a health carrier, third party purchaser, health care provider, health care center, health care facility, governmental entity, or other public payers, corporations, individuals, and consumers who are expecting to collectively cooperate, negotiate, or contract with another collaborator or regional care organizations in the health care system.

"Department" means the Department of Medical Assistance Services or any successor agency of the Commonwealth designated as the "single state agency" to administer the medical assistance program described in Title XIX of the Social Security Act.

"Director" means the Director of the Department.

"Health carrier" has the meaning ascribed to the term in § 38.2-3438.

"HIPAA" means the federal Health Insurance Portability and Accountability Act, 42 U.S.C. § 1320d et seq.

"Medicaid beneficiary" means an individual determined by the Department to be eligible for Medicaid.

"Quality-assurance provisions" means specifications for assessing and improving the quality of care provided by a regional care organization.

"Regional care organization" or "RCO" means an organization of health care providers that contracts with the Department to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the Commonwealth and that meets the requirements set forth in this chapter.

"Risk contract" means a contract under which the contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

§ 32.1-371. Regional care organizations; governing board of directors; citizens' advisory committee; solvency and financial requirements; reporting.

A. A regional care organization shall serve only Medicaid beneficiaries in providing medical care and services.

B. Notwithstanding any other provision of law, a regional care organization shall not be deemed an insurance company under the laws of the Commonwealth.

C. 1. A regional care organization and an organization with probationary regional care organization certification shall have a governing board of directors composed of the following members:

a. Twelve members shall be persons who represent a risk-bearing participant in the regional care organization or organization with probationary certification. A participant bears risk by contributing cash, capital, or other assets to the regional care organization. A participant also bears risk by contracting with the regional care organization to treat Medicaid beneficiaries at a capitated rate per beneficiary or to treat Medicaid beneficiaries even if the regional care organization does not reimburse

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59 *the participant.*

60 *b. Eight members shall be persons who do not represent a risk-bearing participant in the regional*
61 *care organization. Of these eight members, five members shall be medical professionals who provide*
62 *care to Medicaid beneficiaries in the region, of whom three shall be primary care physicians, one shall*
63 *be an optometrist, and one shall be a pharmacist. Of the primary care physicians, one shall be from a*
64 *Federally Qualified Health Center appointed by the Medical Society of Virginia or its successor*
65 *organization and two shall be appointed by a caucus of county boards of health in the region. The*
66 *optometrist shall be appointed by the Virginia Optometric Association or its successor organization. The*
67 *pharmacist shall be appointed by the Virginia Pharmacists Association or its successor organization. All*
68 *five medical professionals shall work in the region served by the regional care organization. None of*
69 *these members shall be a risk-bearing participant in the regional care organization or be an employee*
70 *of a risk-bearing participant, but these members may contract with the regional care organization on a*
71 *fee-for-service basis.*

72 *c. Three members shall be community representatives as follows:*

73 *(1) The chair of the citizens' advisory committee established pursuant to subsection D;*

74 *(2) Another citizens' advisory committee member, elected by the committee, who is a representative*
75 *of a local disability advisory commission in the region; and*

76 *(3) A business executive, nominated by a chamber of commerce in the region, who works in the*
77 *region.*

78 *The community representative members shall not be risk-bearing participants in the regional care*
79 *organization or employees of a risk-bearing participant.*

80 *2. A majority of the members of the board may not represent a single type of provider, such as*
81 *hospitals or doctors engaged in medical practice.*

82 *3. The Department shall have the power to approve the members of the governing board and the*
83 *board's structure, powers, bylaws, or other rules of procedure. No RCO shall be granted probationary*
84 *regional care organization certification or full regional care organization certification without approval.*

85 *4. The regional care organization, the caucus of county boards of health in the region, the citizens'*
86 *advisory committee, and the medical, optometric, and pharmacist associations shall promptly fill any*
87 *vacancy on the board of directors. Notwithstanding other provisions of this subsection, the Director*
88 *shall fill a board seat left vacant for at least three months.*

89 *5. The governing board may not take any action unless at least one physician appointed by a caucus*
90 *of county boards of health in the region, who does not represent a risk-bearing participant and who*
91 *does not hold one of the three seats held by community representatives, votes on the prevailing side.*

92 *6. The membership of the governing board of directors shall be inclusive and reflect the racial,*
93 *gender, geographic, urban-rural, and economic diversity of the region.*

94 *D. A citizens' advisory committee shall advise the RCO on ways the organization may be more*
95 *efficient in providing quality care to Medicaid beneficiaries. In addition, an advisory committee shall*
96 *carry out other functions and duties assigned to it by a regional care organization and approved by the*
97 *Department. Each regional care organization shall have a citizens' advisory committee, as shall an*
98 *organization seeking to become a regional care organization, which membership shall be inclusive and*
99 *reflect the racial, gender, geographic, urban-rural, and economic diversity of the Commonwealth. The*
100 *committee shall:*

101 *1. Be selected in a method established by the organization seeking to become a regional care*
102 *organization, or established by the regional care organization, and approved by the Department;*

103 *2. Have Medicaid beneficiaries as at least 20 percent of its members or, if the organization has been*
104 *certified as a regional care organization, at least 20 percent of its members shall be Medicaid*
105 *beneficiaries enrolled in the regional care organization;*

106 *3. Include members who are representatives of organizations that represent the interests of disabled*
107 *Virginians;*

108 *4. Include only persons who live in the Medicaid region the organization plans to serve or if the*
109 *organization has become a regional care organization, include only persons who live in the Medicaid*
110 *region served by the regional care organization. The membership of the citizens' advisory committee*
111 *shall be inclusive and reflect the racial, gender, geographic, urban/rural, and economic diversity of the*
112 *region;*

113 *5. Elect a chair from among its membership; and*

114 *6. Meet at least every three months.*

115 *E. 1. Each regional care organization shall meet minimum solvency and financial requirements as*
116 *provided in this subsection. The Department shall require a regional care organization, as a condition*
117 *of certification or continued certification, to maintain minimum financial reserves at the following levels:*

118 *a. Restricted reserves of \$250,000 or an amount equal to 25 percent of the regional care*
119 *organization's total actual or projected average monthly expenditures, whichever is greater; and*

120 *b. Capital or surplus, or any combination thereof, of \$2.5 million.*

2. As an alternative to maintaining the financial reserves required in subdivision 1, a regional care organization that has entered into a risk contract with the Department may submit to the agency a written guaranty in the form of a bond issued by an insurer, in an amount equal to the financial reserves that would otherwise be required of the regional care organization under subdivision 1, to guarantee the performance of the provisions of the risk contract. The bond shall be issued by an insurer authorized to transact the business of insurance in the Commonwealth and approved by the Director. No assets of the regional care organization shall be pledged or encumbered for the payment of the performance bond.

F. A regional care organization shall provide such financial reports and information as required by the Department.

G. A regional care organization shall report all data as required by the Department, consistent with HIPAA.

§ 32.1-372. Medicaid regions.

The Department shall establish by regulation geographic Medicaid regions in which a regional care organization or alternate care provider may operate, which together shall cover the entire Commonwealth. Each Medicaid region, according to an actuary working for Medicaid, shall be capable of supporting at least two regional care organizations or alternate care providers.

§ 32.1-373. Contract to provide medical care to Medicaid beneficiaries; enrollment; grievance procedures; duties of Department.

A. Subject to approval of the federal Centers for Medicare and Medicaid Services, the Department shall enter into a contract in each Medicaid region with at least one fully certified regional care organization, under which (i) the RCO shall provide medical care to Medicaid beneficiaries and (ii) the Department shall make capitated payments to the RCO. However, the Department may enter into a contract pursuant to this section only if, in the judgment of the Department, care of Medicaid beneficiaries would be better, more efficient, and less costly than under the then-existing care delivery system. The Department may contract with more than one regional care organization in a Medicaid region. Pursuant to the contract, the Department shall set capitation payments for the regional care organization.

B. The Department shall enroll a majority of the Commonwealth's Medicaid beneficiaries into regional care organizations. If more than one regional care organization operates in a Medicaid region, a Medicaid beneficiary may choose the organization to provide the individual's care. If a Medicaid beneficiary does not make a choice, the Department shall assign the individual to a regional care organization. The Department may limit the circumstances under which a Medicaid beneficiary may change regional care organizations.

C. A regional care organization shall provide Medicaid services to Medicaid enrollees directly or by contract with other providers. The regional care organization shall establish an adequate medical service delivery network as determined by the Department. An alternate care provider contracting with Medicaid shall also establish such an adequate medical service delivery network.

D. The Department shall adopt regulations establishing procedures for safeguarding against wrongful denial of claims and addressing grievances of enrollees in a regional care organization or an alternate care provider. The procedures shall provide for a timely and meaningful right of appeal, by Medicaid enrollees or their providers, of approvals or denials of care, billing and payment issues, bundling matters, and the provision of health care services. The regulations shall include procedures for a fair hearing on all claims or complaints brought by Medicaid enrollees or other providers that shall include the following:

1. An immediate appeal to the medical director of the regional care organization, who shall be a primary care physician. The rules of evidence shall not apply. The medical director shall consider the materials submitted on the issue and any oral arguments and render a decision. The medical director's decision shall be binding on the regional care organization;

2. If a patient or provider is dissatisfied with the decision of the medical director, the patient or provider may file a notice of appeal to be heard by a peer review committee. The peer review committee shall be composed of at least three physicians of the same specialty in the region in which the services or matter is at issue. If three physicians cannot be found, then the physicians may be selected outside of the region. The Department shall develop regulations regarding the appeal to the peer review committee. The peer review committee's decision shall be binding on the regional care organization; and

3. If a patient or the provider is dissatisfied with the decision of the peer review committee, the patient or provider may file a written notice of appeal to the Department. The Department shall adopt rules governing the appeal, which shall include a full evidentiary hearing and a finding on the record. The Department's decision shall be binding upon the regional care organization. However, a patient or provider may file an appeal in circuit court in the locality in which the patient resides or the locality in which the provider provides services.

182 E. The Department shall by rule establish procedures for addressing grievances of regional care
183 organizations. The grievance procedure shall include an opportunity for a hearing before a hearing
184 officer in accordance with Article 3 (§ 2.2-4018 et seq.) of the Administrative Process Act. All costs
185 related to development and implementation of the grievance procedure, including the provision of
186 administrative hearings, shall be borne by the Department.

187 F. In addition to subsections A through E, the Department shall:

188 1. Establish by rule the criteria for probationary and full certification of regional care organizations;

189 2. Establish the quality standards and minimum service delivery network requirements for regional
190 care organizations or alternate care providers to provide care to Medicaid beneficiaries;

191 3. Establish by rule and implement quality assurance provisions for each regional care organization;

192 4. Adopt and implement, at its discretion, requirements for a regional care organization concerning
193 health information technology, data analytics, quality of care, and care-quality improvement;

194 5. Conduct or contract for financial audits of each regional care organization. The audits shall be
195 based on requirements established by the Department by rule or established by law. The audit of each
196 regional care organization shall be conducted at least every three years or more frequently if requested
197 by the Department; and

198 6 Take such other action with respect to regional care organizations or alternate care providers as
199 may be required by federal Medicaid regulations or under terms and conditions imposed by the Centers
200 for Medicare and Medicaid Services in order to assure that payments to the regional care organizations
201 or alternate care providers qualify for federal matching funds.

202 **§ 32.1-374. Quality assurance committee; collection and publication of information.**

203 A. The Department shall create a quality assurance committee appointed by the Director. The
204 members of the committee shall serve two-year terms. At least 60 percent of the members shall be
205 physicians who provide care to Medicaid beneficiaries served by a regional care organization. In
206 making appointments to the committee, the Director shall seek input from the appropriate professional
207 associations.

208 B. The committee shall identify objective outcome and quality measures, including measures of
209 outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health
210 treatment, oral health care, and all other health services provided by coordinated care organizations.
211 Quality measures adopted by the committee shall be consistent with existing state and national quality
212 measures. The Director shall incorporate these measures into regional care organization contracts to
213 hold the organizations accountable for performance and customer satisfaction requirements.

214 C. The committee shall adopt outcome and quality measures annually and adjust the measures to
215 reflect the following:

216 1. The amount of the global budget for a regional care organization;

217 2. Changes in membership of the organization;

218 3. The organization's costs for implementing outcome and quality measures; and

219 4. The community health assessment and the costs of the community health assessment conducted by
220 the organization.

221 D. The Department shall continuously evaluate the outcome and quality measures adopted by the
222 committee pursuant to this section.

223 E. The Department shall utilize available data systems for reporting outcome and quality measures
224 adopted by the committee and take actions to eliminate any redundant reporting or reporting of limited
225 value.

226 F. The Department shall publish the information collected under this section at aggregate levels that
227 do not disclose information otherwise protected by law. The information published shall report, by
228 regional care organizations, quality measures, costs, outcomes, and other information, as specified by
229 the contract between the regional care organization and the Department, that is necessary for the
230 Department to evaluate the value of health services delivered by a regional care organization.

231 **§ 32.1-375. Terms of contracts; cost evaluations.**

232 An initial contract between the Department and a regional care organization shall be for three
233 years, with the option for the Department to renew the contract for not more than two additional
234 one-year periods. The Department shall obtain an independent evaluation of the cost savings, patient
235 outcomes, and quality of care provided by each regional care organization and obtain the results of
236 each regional care organization's evaluation in time to use the findings to decide whether to enter into
237 another multiyear contract with the regional care organization or change the Medicaid region's
238 care-delivery system.

239 **§ 32.1-376. Contracts with alternate care providers.**

240 The Department may contract with an alternate care provider in a Medicaid region only under the
241 terms of this section, as follows:

242 1. If (i) a regional care organization failed to provide adequate service pursuant to its contract, (ii)
243 a regional care organization had its certification terminated, (iii) the Department could not award a

contract to a regional care organization under the terms of § 32.1-373, or (iv) no RCO had been awarded a regional care organization certificate by October 1, 2018, then the Department shall first offer a contract, to resume interrupted service or to assume service in the region, under the conditions of § 32.1-373 to any other regional care organization that the Department judged would meet its quality criteria.

2. If by October 1, 2016, no organization had a probationary regional care organization certification in a region. However, the Department may extend the deadline until January 1, 2017, if it judged an organization was making reasonable progress toward getting probationary certification. If the Department judged that no organization in the region likely would achieve probationary certification by January 1, 2017, then the Department shall let any organization with probationary or full regional care organization certification apply to develop a regional care organization in the region. If at least one organization made such an application, the agency no sooner than October 1, 2017, would decide whether any organization could reasonably be expected to become a fully certified regional care organization in the region and its initial region.

3. If an organization lost its probationary certification before October 1, 2018, the Department shall offer any other organization with probationary or full regional care organization certification, which it judged could successfully provide service in the region and its initial region, the opportunity to serve Medicaid beneficiaries in both regions.

4. The Department may contract with an alternate care provider only if no regional care organization accepted a contract under the terms of subdivision 1, no organization was granted the opportunity to develop a regional care organization in the affected region under the terms of subdivision 2, or no organization was granted the opportunity to serve Medicaid beneficiaries under the terms of subdivision 3.

5. The Department may contract with an alternate care provider under the terms of subdivision 4 only if, in the judgment of the Department, care of Medicaid enrollees would be better, more efficient, and less costly than under the then-existing care delivery system. Medicaid may contract with more than one alternate care provider in a Medicaid region.

§ 32.1-377. Termination of regional care organization certification.

A. The Department shall adopt regulations establishing a procedure for the termination of a regional care organization certification or probationary regional care organization certification for nonperformance of contractual duty or for failure to meet or maintain benchmarks, standards, or requirements provided by this chapter or established by the Department as required by this chapter.

B. Termination of a regional care organization certification or probationary certification shall follow the procedure for a case decision pursuant to Article 3 (§ 2.2-4018 et seq.) of the Administrative Process Act.

§ 32.1-378. Contracts between RCOs and health care providers.

A regional care organization shall contract with any willing hospital, physician, or other health care provider to provide services in a Medicaid region if the provider is willing to accept the payments and terms offered comparable providers. Any provider shall meet licensing requirements set by law, shall have a Medicaid provider number, and shall not otherwise be disqualified from participating in Medicare or Medicaid.

§ 32.1-379. Implementation of chapter.

A. The provisions of this chapter shall be implemented in accordance with the following schedule:

1. Not later than October 1, 2015, the Department shall establish Medicaid regions.

2. Not later than October 1, 2016, an organization seeking to become a regional care organization shall have established a governing board and structure as approved by the Department. An organization may receive probationary certification as a regional care organization upon submission of an application for, and demonstration of, a governing board acceptable to the Department. Probationary certification shall expire no later than October 1, 2018.

3. Not later than April 1, 2017, an organization with probationary regional care organization certification shall have demonstrated to Medicaid's approval the ability to establish an adequate medical service delivery network.

4. Not later than October 1, 2017, an organization with probationary regional care organization certification shall have demonstrated to Medicaid's approval that it has met the solvency and financial requirements for a regional care organization as outlined in this chapter.

5. Not later than October 1, 2018, an organization with probationary regional care organization certification shall demonstrate to Medicaid's approval that it is capable of providing services pursuant to a risk contract.

B. The timeline and benchmarks in subsection A shall not preclude an organization from meeting the timelines and benchmarks at an earlier date.

C. Failure to meet and maintain any one of the benchmarks in subdivisions A 2 through 5 shall

305 constitute grounds for termination of a probationary regional care organization certification or full
306 regional care organization certification. The Department shall award full regional care organization
307 certification to an organization with probationary regional care organization certification if the
308 organization timely meets each of those benchmarks. Failure by an organization to timely meet one or
309 more of those benchmarks shall not prevent the Department, at its sole discretion, from granting full
310 regional care organization certification to the organization as long as it has met all of those
311 benchmarks by October 1, 2018.

312 **§ 32.1-380. Case management services.**

313 The Department may contract for case management services with an organization that has been
314 granted by the Department a probationary regional care organization certification. If the agency has
315 contracted with such an organization, and that organization on or before October 1, 2018, has failed to
316 gain full regional care organization certification or has had its probationary certification terminated,
317 then that organization shall refund half the payments made by the Department to the organization for
318 case-management services paid over the previous 12 months.

319 **§ 32.1-381. Collaboration consistent with state policy; approval of agreements and contracts; state**
320 **action immunity; confidentiality of records; additional duties.**

321 A. The General Assembly declares that collaboration among government entities, health carriers,
322 third party purchasers, and health care providers to identify appropriate service delivery systems and
323 reimbursement methods in order to align incentives in support of integrated and coordinated health care
324 delivery is in the best interest of the public. Collaboration pursuant to this chapter is to provide quality
325 health care at the lowest possible cost to citizens of the Commonwealth who are Medicaid eligible. The
326 General Assembly declares that this health care delivery system affirmatively contemplates the
327 foreseeable displacement of competition, such that any anti-competitive effect may be attributed to the
328 Commonwealth's policy to displace competition in the delivery of a coordinated system of health care
329 for the public benefit. In furtherance of this goal, the General Assembly declares its intent to exempt
330 from state antitrust laws, and provide immunity from federal antitrust laws through the state action
331 doctrine to, collaborators, regional care organizations, and contractors that are carrying out the
332 Commonwealth's policy and regulatory program of health care delivery.

333 B. Collaborators shall apply with the Department for a certificate in order to collaborate with other
334 entities, individuals, or regional care organizations. The applicant shall describe what entities and
335 persons with whom the applicant intends on collaborating or negotiating, the expected effects of the
336 negotiated contract, and any other information the Department deems fit. The applicant shall certify that
337 the bargaining is in good faith and necessary to meet the legislative intent stated in subsection A.
338 Before commencing cooperation or negotiations described in this section, an entity or individual shall
339 possess a valid certificate issued pursuant to subsection C.

340 C. Upon a sufficient showing that the collaboration is in order to facilitate the development and
341 establishment of the regional care organization or health care payment reforms, the Department shall
342 issue a certificate allowing the collaboration. A certificate shall allow collective negotiations,
343 bargaining, and cooperation among collaborators and regional care organizations.

344 D. All agreements and contracts described in subsection A shall be approved by the Director.

345 E. If collaborators or a regional care organization are unable to reach a collaboration agreement
346 contemplated by subsection A, they may request that the Department intervene and facilitate
347 negotiations.

348 F. Notwithstanding any other law, the Director or his designee may engage in any other appropriate
349 state supervision necessary to promote state action immunity under state and federal antitrust laws and
350 may inspect or request additional documentation to verify that the Medicaid laws are implemented in
351 accordance with the legislative findings stated in subsection A.

352 G. The Director may convene collaborators and regional care organizations to facilitate the
353 development and establishment of the regional care organizations and health care payment reforms. Any
354 participation by such entities and individuals shall be on a voluntary basis.

355 H. The Department may do any or all of the following:

- 356 1. Conduct a survey of the entities and individuals concerning payment and delivery reforms;
- 357 2. Collect information from other persons to assist in evaluating the impact of any proposed
358 agreement on the market for health care in the Commonwealth; and
- 359 3. Convene meetings at a time and place that is convenient for the entities and individuals.

360 I. To the extent the collaborators and regional care organizations are participating in good faith
361 negotiations, cooperation, bargaining, or contracting in ways that support the intent of establishment of
362 the regional care organization or other health care payment reforms, those state-authorized
363 collaborators and regional care organizations shall be exempt from the antitrust laws under the state
364 action immunity doctrine.

365 J. All reports, notes, documents, statements, recommendations, conclusions, or other information
366 submitted pursuant to this section, or created pursuant to this section, shall be privileged and

confidential and shall only be used in the exercise of the proper functions of the Department. These confidential records shall not be public records and shall not be subject to disclosure except under HIPAA. Any information subject to civil discovery or production shall be protected by a confidentiality agreement or order. Nothing contained herein shall apply to records made in the ordinary course of business of an individual, corporation, or entity. Documents otherwise available from original sources are not to be construed as immune from discovery or used in any civil proceedings merely because they were submitted pursuant to this section. Nothing in this chapter shall apply to prohibit the disclosure of any information that is required to be released to the federal government or any agency thereof. The Department, in its sole discretion but with input from potential collaborators, may promulgate rules to make limited exceptions to this immunity and confidentiality for the disclosure of information. The exceptions created by the Department shall be narrowly construed.

K. The Department shall actively monitor agreements approved under this chapter to ensure that a collaborator's or regional care organization's performance under the agreement remains in compliance with the conditions of approval. Upon request and not less than annually, a collaborator or regional care organization shall provide information regarding agreement compliance. The Department may revoke the agreement upon a finding that performance pursuant to the agreement is not in substantial compliance with the terms of the contract. Any entity or individual aggrieved by any final decision regarding contracts under this section that are approved by the Department, or presented to the Department, may take judicial appeal as provided for in Article 5 (§ 2.2-4025 et seq.) of the Administrative Process Act.

§ 32.1-382. Adoption of regulations.

The Department may adopt regulations necessary to implement the provisions of this chapter.