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SENATE BILL NO. 715

Offered January 14, 2015

Prefiled December 4, 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 Education and Health

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 (the board) 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 the participant.

b. Eight members shall be persons who do not represent a risk-bearing participant in the regional care organization. Of these eight members, five members shall be medical professionals who provide care to Medicaid beneficiaries in the region, of whom three shall be primary care physicians, one shall be an optometrist, and one shall be a pharmacist. Of the primary care physicians, one shall be from a federally qualified health center appointed by the Medical Society of Virginia or its successor organization and two shall be appointed by a caucus of county boards of health in the region. The optometrist shall be appointed by the Virginia Optometric Association or its successor organization. The pharmacist shall be appointed by the Virginia Pharmacists Association or its successor organization. All five medical professionals shall work in the region served by the regional care organization. None of these members shall be a risk-bearing participant in the regional care organization or be an employee of a risk-bearing participant, but these members may contract with the regional care organization on a fee-for-service basis.

c. Three members shall be community representatives as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Elect a chair from among its membership; and

6. Meet at least every three months.

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

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

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 in 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 beneficiaries 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 the Department 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 beneficiaries 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 beneficiaries 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Changes in membership of the organization;

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

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

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

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

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

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

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

§ 32.1-376. Contracts with alternate care providers.

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

1. If (i) a regional care organization fails to provide adequate service pursuant to its contract, (ii) a

regional care organization has its certification terminated, (iii) the Department cannot award a contract to a regional care organization under the terms of § 32.1-373, or (iv) no RCO has 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 judges would meet its quality criteria.

2. If by October 1, 2016, no organization has a probationary regional care organization certification in a region. However, the Department may extend the deadline until January 1, 2017, if it judges an organization is making reasonable progress toward getting probationary certification. If the Department judges that no organization in the region likely will 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 makes such an application, the Department no sooner than October 1, 2017, shall decide whether any organization may reasonably be expected to become a fully certified regional care organization in the region and its initial region.

3. If an organization loses its probationary certification before October 1, 2018, the Department shall offer any other organization with probationary or full regional care organization certification that it judges 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 accepts a contract under the terms of subdivision 1, no organization is granted the opportunity to develop a regional care organization in the affected region under the terms of subdivision 2, or no organization is 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 beneficiaries 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 constitute grounds for termination of a probationary regional care organization certification or full regional care organization certification. The Department shall award full regional care organization certification to an organization with probationary regional care organization certification if the organization timely meets each of those benchmarks. Failure by an organization to timely meet one or more of those benchmarks shall not prevent the Department, at its sole discretion, from granting full regional care organization certification to the organization as long as it has met all of those benchmarks by October 1, 2018.

§ 32.1-380. Case management services.

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

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

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

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

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

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

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

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

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

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

1. Conduct a survey of the entities and individuals concerning payment and delivery reforms;

2 Collect information from other persons to assist in evaluating the impact of any proposed agreement on the market for health care in the Commonwealth; and

3 Convene meetings at a time and place that is convenient for the entities and individuals.

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

J. All reports, notes, documents, statements, recommendations, conclusions, or other information 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.