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SENATE BILL NO. 5007

Offered September 18, 2014

A BILL to amend the Code of Virginia by adding sections numbered 2.2-515.3 and 2.2-515.4, to amend the Code of Virginia by adding in Title 32.1 a chapter numbered 17, consisting of sections numbered 32.1-370 through 32.1-391, and to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6411, relating to the establishment of Medicaid accountable 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 sections numbered 2.2-515.3 and 2.2-515.4, by adding in Title 32.1 a chapter numbered 17, consisting of sections numbered 32.1-370 through 32.1-391, and by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6411, as follows:

§ 2.2-515.3. Concurrence of Attorney General in determination of competitive impact of accountable care organization.

A. If the State Corporation Commission (Commission), following its determination that an application for a certificate of authority filed under § 38.2-6401 meets the requirements of subdivisions A 3 and 4 of § 38.2-6402, forwards the application, and all data, documents, and analysis considered by the Commission in making the determination to the Attorney General, the Attorney General shall review the application and the data, documents, and analysis and, if the Attorney General concurs with the Commission's determination under subdivisions A 3 and 4 of § 38.2-6402, the Attorney General shall notify the Commission and the Department of Medical Assistance Services.

B. If the Attorney General does not concur with the Commission's determination under subdivisions A 3 and 4 of § 38.2-6402, the Attorney General shall notify the Commission and the Department of Medical Assistance Services.

C. A determination under this section shall be made not later than the sixtieth day after the date the Attorney General receives the application and the data, documents, and analysis from the Commission.

D. If the Attorney General lacks sufficient information to make a determination under subdivisions A 3 and 4 of § 38.2-6402 , within 60 days of the Attorney General's receipt of the application and the data, documents, and analysis the Attorney General shall inform the Commission that the Attorney General lacks sufficient information as well as what information the Attorney General requires. The Commission shall then either provide the additional information to the Attorney General or request the additional information from the applicant. The Commission shall promptly deliver any such additional information to the Attorney General. The Attorney General shall then have 30 days from receipt of the additional information to make a determination under subsection A or B.

E. If the Attorney General notifies the Commission that the Attorney General does not concur with the Commission's determination under subdivisions A 3 and 4 of § 38.2-6402, then the Commissioner shall deny the application for a certificate of authority under Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2.

F. In reviewing the Commission's determination, the Attorney General shall consider the findings, conclusions, or analyses contained in any other governmental entity's evaluation of the accountable care organization.

G. The Attorney General at any time may request from the Commission additional time to consider an application under this section. The Commission shall grant the request and notify the applicant of the request. A request by the Attorney General or an order by the Commission granting a request under this section is not subject to administrative or judicial review.

§ 2.2-515.4. Authority of Attorney General with respect to accountable care organizations.

A. The Attorney General may:

1. Investigate an accountable care organization (ACO) with respect to anticompetitive behavior that is contrary to the goals and requirements of Chapter 17 (§ 32.1-370 et seq.) of Title 32.1 and Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2; and

2. Request that the State Corporation Commission or the Department of Medical Assistance Services:

a. Impose a penalty or sanction on an ACO;

b. Issue a cease and desist order against an ACO; or

c. Suspend or revoke the ACO's certificate of authority.

B. This section shall not be construed to limit any other authority or power of the Attorney General.

CHAPTER 17.

MEDICAID ACCOUNTABLE CARE ORGANIZATIONS.

§ 32.1-370. Definitions.

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

"Accountable care organization" or "ACO" means a corporation, whose shareholders are physicians and other health care providers, that is organized for the primary purpose of providing, or arranging for the provision of, health care services by its shareholders to Medicaid beneficiaries under a system under which payments are made by the Department using innovative payment methodologies.

"Affiliate" means a person who controls, is controlled by, or is under common control with one or more other persons.

"Board" means the Board of Medical Assistance Services.

"Commission" means the State Corporation Commission.

"Department" means the Department of Medical Assistance Services.

"Innovative payment methodologies" include capitated payments, gainsharing payment arrangements, pay-for-performance, quality-based payments, and other payment arrangements whereby the costs of health care services provided to Medicaid beneficiaries by health care providers participating in an ACO are less than such costs would be if provided on a fee for service basis and a portion of the cost savings are distributed among the health care providers participating in the ACO.

"Health care provider" means any person, partnership, professional association, corporation, facility, or institution licensed, certified, registered, or chartered by the Commonwealth to provide health care services.

"Health care services" means services provided by a physician or other health care provider to prevent, alleviate, cure, or heal human illness or injury. "Health care services" includes pharmaceutical services, medical, chiropractic, or dental care, and hospitalization.

"Medicaid" means the medical assistance services program operating in the Commonwealth pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.

"Secretary" means the Secretary of Health and Human Resources.

§ 32.1-371. Implementation of a care delivery system utilizing ACOs.

A. The Department, within 180 days following receipt of approval of the federal Centers for Medicare and Medicaid Services, shall establish a schedule that provides for the implementation, within two years following the establishment of the schedule, of a health care services delivery system whereby the Department will arrange for the provision of health care services to a majority of the Commonwealth's Medicaid beneficiaries through contracts with ACOs. Such health care services delivery system utilizing ACOs shall be established and implemented by the Department in a manner consistent with the requirements of this chapter.

B. The Department shall use, to the greatest extent possible, ACOs to provide fully integrated physical health services, chemical dependency and mental health services, and oral health services. This chapter, and any contract entered into pursuant to this chapter, shall not affect and does not alter the delivery of Medicaid-funded long-term care services.

§ 32.1-372. Department to contract with ACOs.

A. The Department shall enter into contracts with ACOs that meet the criteria set forth in this chapter and Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2.

B. The Department shall require compliance with the provisions of § 38.2-6410 as a condition of entering into a contract with an ACO.

§ 32.1-373. Operations of ACOs.

An accountable care organization that is certified by the Commission under Chapter 64 (§ 38.2-6400 et seq.) may provide or arrange to provide health care services to Medicaid beneficiaries under contract with the Department.

§ 32.1-374. Enrollment of Medicaid beneficiaries.

A. Individuals eligible for medical assistance under the Commonwealth's Medicaid program shall be eligible for enrollment in a health care delivery system operated by an ACO.

B. An eligible Medicaid beneficiary may enroll in a health care delivery system operated by an ACO if a system serves the county in which the individual resides. If more than one health care delivery system operated by an ACO serves a county, the individual shall be allowed to choose among the systems. The Department may assign an individual to such a health care delivery system if a system is available and no choice has been made by the individual.

§ 32.1-375. Formation and governance of ACO.

A. An ACO shall be governed by a board of directors.

B. The person who establishes an ACO shall appoint an initial board of directors. Each member of the initial board shall serve a term of not more than 18 months. Subsequent members of the board shall be elected to serve two-year terms by health care providers who participate in the ACO as provided by

this section. The board shall elect a chair from among its members.

C. If the participants in an ACO are all physicians, each member of the board of directors shall be an individual physician who is a participant in the ACO.

D. If the participants in an ACO are both physicians and other health care providers, the board of directors shall consist of:

1. An even number of members who are individual physicians, selected by physicians who participate as shareholders in the ACO;

2. A number of members equal to the number of members under subdivision 1 who represent nonphysician health care providers, at least one of whom is an individual physician, selected by such health care providers who participate as shareholders in the ACO; and

3. One individual member with business expertise, selected by unanimous vote of the members described by subdivisions 1 and 2.

E. If an ACO includes hospital-based physicians, one member of the board of directors shall be a hospital-based physician.

F. The board of directors shall include at least three nonvoting members who represent the community in which the ACO operates.

G. An individual shall not serve on the board of directors of an ACO if the individual has an ownership interest in, serves on the board of directors of, or maintains an officer position with another accountable care organization that provides health care services in the same service area as the ACO or a physician or health care provider that (i) does not participate in the ACO and (ii) provides health care services in the same service area as the ACO.

H. In addition to the requirements of subsection G, the board of directors of an ACO shall adopt a conflict of interest policy to be followed by members.

I. The board of directors may remove a member of the board for cause. A member may not be removed from the board without cause.

J. The organizational documents of an accountable care organization may not conflict with any provision of this chapter.

§ 32.1-376. Compensation advisory committee; sharing of certain data.

A. The board of directors of an ACO shall establish a compensation advisory committee to develop and make recommendations to the board regarding charges, fees, payments, distributions, or other compensation assessed for health care services provided by physicians or other health care providers who participate as shareholders in the ACO. The committee shall include:

1. Two members of the board of directors, of which one member is the hospital-based physician member if the ACO includes hospital-based physicians; and

2. If the ACO consists of physicians and other health care providers:

a. A physician who is not a participant in the ACO, selected by the physicians who are participants in the ACO; and

b. A member of the board of directors selected by the other health care providers who participate in the ACO.

B. An accountable care organization shall establish and enforce policies to prevent the sharing of charge, fee, and payment data among nonparticipating health care providers.

C. The compensation advisory committee shall make recommendations to the board of directors regarding all charges, fees, payments, distributions, or other compensation assessed for health care services provided by a health care provider who participates as a shareholder in the ACO.

§ 32.1-377. Certificate of authority from State Corporation Commission required.

A. An entity may not organize or operate an ACO in the Commonwealth unless the entity holds a certificate of authority issued by the Commission pursuant to Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2.

B. In addition, an entity may not organize or operate an ACO in the Commonwealth unless the Department has found that:

1. With respect to health care services to be provided, the entity:

a. Has demonstrated the willingness and potential ability to ensure that the health care services will be provided in a manner that:

(1) Increases collaboration among health care providers and integrates health care services;

(2) Promotes improvement in quality-based health care outcomes, patient safety, patient engagement, and coordination of services; and

(3) Reduces the occurrence of potentially preventable events;

b. Has processes that contain health care costs without jeopardizing the quality of patient care;

c. Has processes to develop, compile, evaluate, and report statistics on performance measures relating to the quality and cost of health care services, the pattern of utilization of services, and the availability and accessibility of services; and.

d. Has processes to address complaints made by patients receiving services provided through the organization; and

2. The entity is in compliance with all regulations adopted by the Board.

§ 32.1-378. Providing or arranging for services.

A. An ACO may provide or arrange for health care services through contracts with health care providers or with entities contracting on behalf of participating health care providers.

B. An ACO shall not prohibit a physician or other health care provider, as a condition of participating in the ACO, from participating in another ACO.

C. An ACO shall not use a covenant not to compete to prohibit a physician from providing medical services or participating in another ACO in the same service area.

§ 32.1-379. Payments by Department.

A. An ACO that is in compliance with this chapter and Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2 may contract for and accept payments from the Department and distribute such payments to participating health care providers for all or part of the cost of services provided or arranged for by the ACO on the basis of the innovative payment methodology for which provision is made in the ACO's contract with the Department.

B. In developing innovative payment methodologies, the Department may establish a gainsharing payment model to be paid for services provided to the recipients enrolled in a health care delivery system.

C. Innovative payment methodologies may include incentive payments to health care delivery systems that meet or exceed annual quality and performance targets realized through the coordination of care.

D. A contract that provides for an ACO to receive and distribute gainsharing payments or other innovative payment methodologies shall not be valid until the Department has approved a plan therefor, which approval may be requested by the ACO at the time of certification or at any time within one year after certification. An ACO may seek to amend its innovative payment plan at any time following the plan's initial approval by submitting amendments to the Department for approval. The Department shall approve only those innovative payment plans that promote improvements in health outcomes and quality of care, as measured by objective benchmarks as well as patient experience of care; expanded access to primary and behavioral health care services; and the reduction of unnecessary and inefficient costs associated with care rendered to Medicaid beneficiaries. Criteria to be considered by the Department shall include: (i) whether the plan promotes care coordination through multidisciplinary teams, including care coordination of patients with chronic diseases and the elderly; expansion of the medical home and chronic care models; increased patient medication adherence and use of medication therapy management services; use of health information technology and sharing of health information; and use of open access scheduling in clinical and behavioral health care settings; (ii) whether the plan encourages services such as patient or family health education and health promotion, home-based services, telephonic communication, group care, and culturally and linguistically appropriate care; (iii) whether the gainsharing payment system is structured to reward quality and improved patient outcomes and experience of care; and (iv) whether the plan funds interdisciplinary collaboration between behavioral health and primary care providers for patients with complex care needs likely to inappropriately access an emergency department and general hospital for preventable conditions. The plan shall include an appropriate proposed time period beginning and ending on specified dates, which shall be the benchmark period against which cost savings can be measured on an annual basis going forward. Savings shall be calculated in accordance with a methodology that:

1. Identifies expenditures per recipient by the Medicaid fee-for-service program during the benchmark period, adjusted for characteristics of recipients and local conditions that predict future Medicaid spending but are not amenable to the care coordination or management activities of an ACO which shall serve as the benchmark payment calculation;

2. Compares the benchmark payment calculation to amounts paid by the Medicaid fee-for-service program for all such resident recipients during subsequent periods; and.

3. Provides that the benchmark payment calculation shall remain fixed for a period of three years following approval of the plan.

E. The percentage of cost savings identified pursuant to an innovative payment methodology to be distributed to the ACO and retained by the Commonwealth shall be identified in the plan and shall remain in effect for a period of three years following approval of the plan. Such percentages shall be designed to ensure that the Commonwealth can achieve meaningful savings and support the ongoing operation of the program and that the ACO receives a sufficient portion of the shared savings necessary to achieve its mission and expand its scope of activities.

F. Notwithstanding the provisions of this section to the contrary, the Department shall not approve an innovative payment plan that provides direct or indirect financial incentives for the reduction or limitation of medically necessary and appropriate items or services provided to patients under a health care provider's clinical care in violation of federal law.

G. The Department shall encourage ACOs to use innovative payment methodologies that:

1. Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;

2. Hold ACOs and providers responsible for the efficient delivery of quality care;

3. Reward good performance;

4. Limit increases in medical costs; and

5. Use payment structures that create incentives to (i) promote prevention, (ii) provide person-centered care, and (c) reward comprehensive care coordination using delivery models such as patient-centered primary care homes;

H. The Department shall encourage ACOs to utilize alternative payment methodologies that move from a predominantly fee-for-service system to payment methods that base reimbursement on the quality rather than the quantity of services provided.

I. The Department shall assist and support ACOs in identifying cost-cutting measures.

§ 32.1-380. Contracts for administrative or management services.

An ACO may contract with any person, including an affiliate, to perform administrative, management, or any other required business functions on behalf of the ACO.

§ 32.1-381. Quality and costs of health care services.

A. An ACO shall establish policies to improve the quality and control the cost of health care services provided by participating health care providers that are consistent with prevailing professionally recognized standards of medical practice. The policies shall include standards and procedures relating to:

1. The selection and credentialing of participating health care providers;

2. The development, implementation, monitoring, and evaluation of evidence-based best practices and other processes to improve the quality and control the cost of health care services provided by participating health care providers, including practices or processes to reduce the occurrence of potentially preventable events; and

3. The development, implementation, monitoring, and evaluation of processes to improve patient engagement and coordination of health care services provided by participating health care providers.

B. The board of directors of an ACO shall establish a procedure for the periodic review of quality improvement and cost control measures.

§ 32.1-382. Complaints.

A. An ACO shall implement and maintain complaint systems that provide reasonable procedures to resolve an oral or written complaint initiated by:

1. A patient who received health care services provided by a participating health care provider; or

2. A participating health care provider.

B. The complaint system for complaints initiated by patients shall include a process for the notice and appeal of a complaint.

C. An ACO shall not take a retaliatory or adverse action against a health care provider who files a complaint with a regulatory authority regarding an action of the ACO.

§ 32.1-383. Rights of physicians.

A. Before a complaint against a physician under § 32.1-382 is resolved, or before a physician's association with an ACO is terminated, the physician is entitled to an opportunity to dispute the complaint or termination through a process that includes:

1. Written notice of the complaint or basis of the termination;

2. An opportunity for a hearing not earlier than the thirtieth day after receiving notice under subdivision 1;

3. The right to provide information at the hearing, including testimony and a written statement; and

4. A written decision that includes the specific facts and reasons for the decision.

B. An ACO may limit a physician or group of physicians from participating in the ACO if the limitation is based on an established development plan approved by the board of directors. Each applicant physician or group shall be provided with a copy of the development plan.

§ 32.1-384. Regulations.

The Board may adopt reasonable regulations as necessary and proper to implement the provisions of this chapter.

§ 32.1-385. Fees; assessments.

A. The Board shall, within the limits prescribed by this section, prescribe the fees to be charged and the assessments to be imposed under this chapter.

B. An ACO shall pay to the Department:

1. An application fee in an amount determined by the Board; and

2. An annual assessment in an amount determined by the Board.

C. The Board shall set fees and assessments under this section in an amount sufficient to pay the

reasonable expenses of the Department in administering this chapter, including the expenses incurred in examining and reviewing ACOs. Fees and assessments imposed under this section shall be allocated among ACOs on a pro rata basis to the extent that the allocation is feasible.

§ 32.1-386. Enforcement actions.

A. After notice and opportunity for a hearing, the Board may:

1. Suspend or revoke a certificate of authority issued to an ACO under this chapter;

2. Seek the imposition of sanctions under §§ 32.1-27 and 32.1-27.1; or

3. Issue orders to require any person to comply with the provisions of any this chapter or any regulations promulgated under this chapter. Any such order shall be issued only after a hearing with at least30 days' notice to the affected person of the time, place and purpose thereof. Such order shall become effective not less than 15 days after mailing a copy thereof by certified mail to the last known address of such person.

B. The Board may take an enforcement action listed in subsection A against an ACO if the Board finds that the ACO:

1. Is operating in a manner that is:

a. Significantly contrary to its basic organizational documents; or

b. Contrary to the manner described in and reasonably inferred from other information submitted under § 32.1-377 or 38.2-6402;

2. Does not meet the requirements of this chapter or Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2;

3. Cannot fulfill its obligation to provide health care services as required under its contracts with the Department;

4. Has not implemented the complaint system required by § 32.1-382 in a manner to resolve reasonable complaints;

5. Has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner or a person on behalf of the ACO has advertised or merchandised the ACO's services in an untrue, misrepresentative, misleading, or deceptive manner;

6. Has not complied substantially with this chapter or a regulation adopted under this chapter;

7. Has not taken corrective action the Board considers necessary to correct a failure to comply with this chapter, any applicable provision of law, or any applicable rule or order not later than the thirtieth day after the date of notice of the failure or within any longer period specified in the notice and determined by the Board to be reasonable; or

8. Has or is utilizing market power in an anticompetitive manner, in accordance with established antitrust principles of market power analysis.

§ 32.1-387. Operations during suspension or after revocation of certificate of authority.

A. During the period a certificate of authority of an ACO is suspended, the ACO shall not:

1. Enter into a new contract with the Department; or

2. Advertise or solicit in any way.

B. After a certificate of authority of an ACO is revoked, the ACO:

1. Shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs;

2. Shall not conduct further business except as essential to the orderly conclusion of its affairs; and

3. May not advertise or solicit in any way.

C. Notwithstanding subsection B, the Board by written order may permit the further operation of the ACO to the extent that the Board finds necessary to serve the best interest of the Department under its contracts with the ACO.

§ 32.1-388. Injunctions.

If the Board believes that an ACO or another person is violating or has violated this chapter or a regulation adopted under this chapter, the Board may bring an action to enjoin the violation and obtain other relief the court considers appropriate.

§ 32.1-389. Notice of enforcement action.

The Department shall:

1. Report any enforcement action taken under this chapter to:

a. The relevant licensing or certifying agency or board; and

b. The U.S. Department of Health and Human Services National Practitioner Data Bank; and

2. Post notice of the action on the Department's website.

§ 32.1-390. Applications for waivers and grants.

A. The Secretary shall submit an application for any necessary waivers, including, if applicable, a waiver for state innovation pursuant to 42 U.S.C. § 18052, or other federal approval required to implement this chapter.

B. The Secretary shall seek from the Office of the Inspector General in the U.S. Department of Health and Human Services the following:

1. A waiver of the provisions of, or expansion of the safe harbors to 42 U.S.C. 1320a-7b and

implementing regulations or any other necessary authorization the Secretary determines may be necessary to permit certain shared risk and other risk-sharing arrangements among ACOs and health care providers; and

2. A waiver of or exemption from the provisions of 42 U.S.C. § 1395nn(a) to (e) and implementing regulations or other authorization the Secretary determines may be necessary to permit physician referrals to other providers as needed to support the transition to and implementation of global and alternative payment systems and formation of coordinated care organizations.

C. The Secretary shall apply for any applicable grant or demonstration under the Patient Protection and Affordable Care Act, P.L. 111-148, or the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, that would further the purposes of or assist in the establishment of accountable care organizations.

§ 32.1-391. Federal approvals.

A. The Secretary may seek federal approval to:

1. Enroll in coordinated care organizations individuals who are dually eligible for Medicare and Medicaid, integrate Medicare Advantage plans into ACOs, and implement the contracting procedures and blended reimbursement methods for ACOs that include members who are dually eligible for Medicare and Medicaid. The Secretary may not seek approval to alter any of the rights or benefits of Medicare beneficiaries under Title XVIII of the Social Security Act;

2. Support the transition to and implementation of global and alternative payment systems and the formation and utilization of coordinated care organizations in the medical assistance program; and

3. Permit the use and reimbursement of nontraditional personnel, such as community health workers, personal health navigators, and peer wellness specialists, and permit delivery of health services, supports, and supplies that have not traditionally been delivered through the Medicaid program.

B. The Department shall adopt regulations and execute contracts with ACOs as soon as practicable following receipt of the necessary federal approval. The Secretary may provide for implementation in stages.

CHAPTER 64.

CERTIFICATION OF ACCOUNTABLE CARE ORGANIZATIONS.

§ 38.2-6400. Definitions.

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

"Accountable care organization" or "ACO" has the same meaning ascribed to the term in § 32.1-370.

"Affiliate" means a person who controls, is controlled by, or is under common control with one or more other persons.

"Department" means the Department of Medical Assistance Services.

"Medicaid" means the medical assistance services program operating in the Commonwealth pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.

§ 38.2-6401. Application for certificate of authority.

A. A person may apply to the Commission for and obtain a certificate of authority to organize and operate an ACO.

B. An application for a certificate of authority shall:

1. Comply with all regulations adopted by the Commission pursuant to this chapter;

2. Be verified under oath by the applicant or an officer or other authorized representative of the applicant;

3. Be reviewed by the Office of the Attorney General that is primarily responsible for enforcing the antitrust laws of the Commonwealth and of the United States pursuant to § 2.2-515.3;

4. Demonstrate that the ACO contracts with a sufficient number of primary care physicians in the accountable care organization's service area;

5. State that enrollees may obtain care from any health care provider in the ACO; and

6. Identify a service area within which health care services are available and accessible to enrollees.

C. Not later than 90 days after the date an applicant submits an application to the Commission under this section, the Commission shall approve or deny the application.

D. The Commissioner by rule may:

1. Extend the date by which an application is due under this section; and

2. Require the disclosure of any additional information necessary to implement and administer this chapter, including information necessary to antitrust review and oversight.

§ 38.2-6402. Requirements for approval of applications.

A. The Commission shall issue a certificate of authority on payment of the application fee prescribed by § 38.2-6407 if the Commission finds that:

1. The applicant meets the requirements of § 38.2-6401;

2. The applicant maintains working capital and reserves sufficient to operate and maintain the ACO and to arrange for services and expenses incurred by the ACO, which amounts shall be set by

regulation;

3. The applicant's proposed ACO is not likely to reduce competition in any market for physician, hospital, or ancillary health care services due to:

a. The size of the ACO; or

b. The composition of the ACO, including the distribution of physicians by specialty within the ACO in relation to the number of competing health care providers in the ACO's geographic market; and

4. The pro-competitive benefits of the applicant's proposed ACO are likely to substantially outweigh the anticompetitive effects of any increase in market power.

B. If the Commissioner determines that an application for a certificate of authority filed under this chapter complies with the requirements of subdivisions A 3 and 4, the Commission shall forward the application, and all data, documents, and analysis considered by the Commissioner in making the determination, to the Attorney General for review pursuant to § 2.2-515.3.

C. A certificate of authority is effective for a period of one year.

§ 38.2-6403. Denial of application for certificate.

A. The Commission shall not issue a certificate of authority if the Commission determines that the applicant's proposed plan of operation does not meet the requirements of § 38.2-6402.

B. If the Commission denies an application for a certificate of authority under subsection A, the Commission shall notify the applicant that the plan is deficient and specify the deficiencies.

§ 38.2-6404. Renewal of certificate of authority.

A. Not later than the 180th day before the one-year anniversary of the date on which an ACO's certificate of authority was issued or most recently renewed by the Commission, the ACO shall file with the Commission an application to renew the certificate.

B. An application for renewal shall:

1. Be verified by at least two principal officers of the ACO; and

2. Include:

a. A financial statement of the ACO, including a balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent certified public accountant;

b. A description of the service area of the ACO;

c. A description of the number and types of health care providers participating in the ACO;

d. An evaluation of the quality and cost of health care services provided by the ACO;

e. An evaluation of the ACO's processes to promote evidence-based medicine, patient engagement, and coordination of health care services provided by the ACO;

f. The number, nature, and disposition of any complaints filed with the ACO under § 32.1-382; and

g. Any other information required by the Commission.

C. If a completed application for renewal is filed under this section:

1. The Commission shall conduct a review under § 38.2-6402 as if the application for renewal were a new application, and, on approval by the Commission, the Attorney General shall review the application under § 2.2-515.3 as if the application for renewal were a new application; and

2. The Commission shall renew or deny the renewal of a certificate of authority at least 20 days before the one-year anniversary of the date on which an ACO's certificate of authority was issued.

D. If the Commission does not act on a renewal application before the one-year anniversary of the date on which an ACO's certificate of authority was issued or renewed, the ACO's certificate of authority expires on the ninetieth day after the date of the one-year anniversary unless the renewal of the certificate of authority or determination of approval, as applicable, is approved before that date.

E. An ACO shall report to the Commission a material change in the size or composition of the ACO. On receipt of a report under this subsection, the Commission may require the ACO to file an application for renewal before the date required by subsection A.

§ 38.2-6405. Insurance, reinsurance, indemnity, and reimbursement.

An ACO may contract with an insurer authorized to engage in business in the Commonwealth to provide insurance, reinsurance, indemnification, or reimbursement against the cost of health care services provided by the ACO. This section does not affect the requirement that the ACO maintain sufficient working capital and reserves.

§ 38.2-6406. Regulations.

The Commission may adopt reasonable regulations as necessary and proper to implement the provisions of this chapter.

§ 38.2-6407. Fees.

A. The Commission shall prescribe the fees to be charged and the assessments to be imposed under this section.

B. An ACO shall pay to the Commission an application fee in an amount determined by Commission regulation and an annual assessment in an amount determined by Commission regulation.

C. The Commission shall set fees and assessments under this section in an amount sufficient to pay the reasonable expenses of the Commission in administering this chapter, including the direct and

indirect expenses incurred in examining and reviewing ACOs. Fees and assessments imposed under this section shall be allocated among ACOs on a pro rata basis to the extent that the allocation is feasible.

§ 38.2-6408. Examinations.

A. The Commission may examine the financial affairs and operations of any ACO or applicant for a certificate of authority under this chapter.

B. An ACO shall make its books and records relating to its financial affairs and operations available for an examination by the Commission.

C. On request of the Commission, an ACO shall provide to the Commission:

1. A copy of any contract, agreement, or other arrangement between the ACO and a health care provider; and

2. A general description of the fee arrangements between the ACO and the health care provider.

D. The Commission may disclose the results of an examination conducted under this section or documentation provided under this section to a governmental agency that contracts with an ACO for the purpose of determining financial stability, readiness, or other contractual compliance needs.

§ 38.2-6409. When licensure requirements waived.

Notwithstanding any requirement of this title to the contrary, an ACO shall not be required to obtain licensure from the Commission as an insurer or health maintenance organization when providing health care services to Medicaid beneficiaries.

§ 38.2-6410. Financial reporting requirements.

The Commission shall establish financial reporting requirements for ACOs. The Commission shall prescribe a reporting procedure that elicits sufficiently detailed information for the Commission to assess the financial condition of each ACO and that enables the Commission to verify that the ACO's reserves and other financial resources are adequate to ensure against the risk of insolvency.

§ 38.2-6411. Use of insurance-related terms by ACO.

An ACO shall not use in its name, contracts, or literature the following words or initials: "insurance"; "casualty"; "surety"; "mutual"; "health maintenance organization"; or "HMO." In addition, an ACO shall not use in its name, contracts, or literature any other words or initials that are (i) descriptive of the insurance, casualty, surety, or health maintenance organization business or (ii) deceptively similar to the name or description of an insurer, surety corporation, or health maintenance organization engaging in business in the Commonwealth.