SB431

168266-1

By Senators Reed, Marsh, and Waggoner

RFD: Health and Human Services

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SYNOPSIS: This bill would provide for the delivery of long-term care services to certain elderly and disabled Medicaid beneficiaries on a managed care basis through one or more statewide integrated care networks.

This bill would establish requirements for the operation of an integrated care network under the Medicaid Program and would require the network to be governed by a board of directors. This bill would also provide for the creation of a citizens' advisory committee to advise the network.

A BILL

TO BE ENTITLED

AN ACT

Relating to the Medicaid Agency; to amend Section 22-6-160 of the Code of Alabama 1975, to provide for the delivery of long-term care services to certain elderly and disabled Medicaid beneficiaries on a managed care basis

through one or more statewide integrated care networks; and to establish requirements for the governance and operation of the integrated care network.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Section 22-6-160, Code of Alabama 1975, is amended to read as follows:

"§22-6-160.

"~~(a) The Medicaid Agency, with input from long-term care providers, shall conduct an evaluation of the existing long-term care system for Medicaid beneficiaries and, on October 1, 2015, shall report the findings of the evaluation to the Legislature and Governor.~~

"~~(b)~~ The Medicaid Agency shall decide which groups of Medicaid beneficiaries to include for coverage by a regional care organization or alternate care provider. The Medicaid Agency, without the approval of the Governor, shall not make a coverage decision that would affect Medicaid beneficiaries who are directly served by another state agency.

"~~(c) Notwithstanding the above, the current Medicaid long-term care programs shall continue as currently administered by the Medicaid Agency until the end of the fiscal year when the evaluation required in subsection (a) is reported to the Legislature and the Governor.~~"

Section 2. For the purposes of this act, the following words shall have the following meanings:

(1) CAPITATION PAYMENT. A payment the state Medicaid

Agency makes periodically to the integrated care network on behalf of each recipient enrolled under a contract for the provision of medical services pursuant to this act.

(2) COLLABORATOR. A private health carrier, third party purchaser, provider, health care center, health care facility, state and local governmental entity, or other public payers, corporations, individuals, and consumers who are expecting to collectively cooperate, negotiate, or contract with another collaborator, or integrated care network in the health care system.

(3) INTEGRATED CARE NETWORK. One or more statewide organizations of health care providers, with offices in each regional care organization region, that contracts with the Medicaid Agency to provide Medicaid benefits to certain Medicaid beneficiaries as defined in subdivision (4) and that meets the requirements set forth in this act. The number of integrated care networks shall be based on actuarial soundness as determined by the Medicaid Agency.

(4) MEDICAID BENEFICIARIES. As used in this act, those Medicaid beneficiaries who have been determined eligible for Medicaid benefits in a nursing facility or home and community based waiver programs covered by the Medicaid state plan, who have also been determined by a qualified provider to meet the level of care for skilled nursing facility services, and those Medicaid beneficiaries who are also eligible for Medicare coverage, under Title XVIII of the Social Security

Act, and who are assigned by Medicaid to the integrated care network.

(5) LONG-TERM CARE SERVICES. Medicaid-funded nursing facility services, home-based and community-based support services, or such other long-term care services as the Medicaid Agency may determine by rule provided to certain Medicaid beneficiaries defined in subdivision (4).

(6) MEDICAID AGENCY. The Alabama Medicaid Agency or any successor agency of the state designated as the single state agency to administer the medical assistance program described in Title XIX of the Social Security Act.

(7) QUALITY ASSURANCE PROVISIONS. Specifications for assessing and improving the quality of care provided by the integrated care network.

(8) REGIONAL CARE ORGANIZATION. An organization of health care providers that contracts with the Medicaid Agency to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the state.

(9) RISK CONTRACT. A long-term care contract with a fully certified integrated care network under which the integrated care network 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 and which is competitively bid.

Section 3. (a) An integrated care network shall serve only Medicaid beneficiaries in providing medical care and services. For the purposes of this act, a beneficiary

cannot be a member of both an integrated care network and a regional care organization.

(b) An integrated care network shall provide required medical care and services to Medicaid beneficiaries and may coordinate care provided by or through an affiliation of other health care providers or other programs as the Medicaid Agency shall determine.

(c) Notwithstanding any other provision of law, the integrated care network shall not be deemed an insurance company under state law.

(d)(1) An integrated care network shall have a governing board of directors composed of the following members:

a. Twelve members shall be persons representing risk bearing participants. A participant bears risk by contributing cash, capital, or other assets to the integrated care network.

b. Eight members shall be persons who do not represent a risk bearing participant in the integrated care network and are not employed by a risk bearing participant.

c. A majority of the board may not represent a single provider. The Medicaid Agency may promulgate rules providing for the criteria and selection of risk bearing and non-risk bearing participants on the board of directors.

(2) Any provider represented on the governing board shall meet licensing requirements set by law, shall have a valid Medicaid provider number, and shall not otherwise be disqualified from participating in Medicare or Medicaid.

(3) The Medicaid Agency shall approve the members of the governing board and the board's structure, powers, bylaws, or other rules of procedure. No organization shall be granted integrated care network certification without approval.

(4) Any vacancy on the governing board of directors in connection with non-risk bearing directors shall be filled in accordance with rules promulgated by the Medicaid Agency. A vacancy in a board of directors' seat held by a representative of a risk bearing participant as defined herein, shall be filled by a majority vote of the remaining directors of the integrated care network. Notwithstanding other provisions of this subsection, the Medicaid Commissioner shall fill a board seat left vacant for more than three months.

(5) All appointing authorities for the governing board shall coordinate their appointments so that diversity of gender, race, and geographical areas is reflective of the makeup of the state.

Section 4. There shall be a citizens' advisory committee constituted to advise the integrated care network on ways the integrated care network may be more efficient in providing quality care to Medicaid beneficiaries. In addition, the advisory committee shall carry out other functions and duties assigned to it by the integrated care network and approved by the Medicaid Agency. The committee shall meet all of the following criteria:

(1) Be selected in a method established by the organization seeking to become an integrated care network, or

established by an integrated care network, and approved by the Medicaid Agency.

(2) At least 20 percent of its members shall be Medicaid beneficiaries or sponsors of Medicaid beneficiaries or, if the organization has been certified as an integrated care network, at least 20 percent of its members shall be Medicaid beneficiaries enrolled in the integrated care network, or their sponsor.

(3) Include members who are representatives of organizations that are part of the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations, the Alabama chapter of AARP, the Alabama Disability Advocacy Program, and the Disability Rights and Resources, and also include members who are non-at-risk providers that provide services to Medicaid beneficiaries through the integrated care network.

(4) Be inclusive and reflect the racial, gender, geographic, and diversity of the region.

(5) Elect a chair.

(6) Meet at least every three months.

Section 5. An integrated care network shall meet minimum solvency and financial requirements as provided by the Medicaid Agency. The Medicaid Agency shall require the integrated care network, as a condition of certification or continued certification, to maintain minimum solvency and financial reserves. The Medicaid Agency shall hereafter promulgate rules setting forth requirements for minimum

solvency, financial reserves, and other financial requirements of an integrated care network based on the number of integrated care networks that may be certified and based on actuarial soundness as determined by the Medicaid Agency. The Medicaid Agency shall allow for the requirements to be met through the submission of an irrevocable letter of credit in an amount equal to the financial reserves that would otherwise be required of the integrated care network, to guarantee the performance of the provisions of the risk contract. If an irrevocable letter of credit is used, it shall be issued by a federally or Alabama state chartered banking institution with assets in excess of four billion dollars ($4,000,000,000) and in a form approved by the Medicaid Agency. No assets of the integrated care network shall be pledged or encumbered in connection with the irrevocable letter of credit.

(b) An integrated care network shall provide financial reports and information as required by the Medicaid Agency.

(c) An integrated care network shall report all data as required by the Medicaid Agency, consistent with the federal Health Insurance Portability and Accountability Act (HIPAA).

Section 6. (a) Subject to approval of the federal Centers for Medicare and Medicaid Services, the Medicaid Agency shall enter into contracts with one or more integrated care networks to provide, pursuant to a risk contract under which the Medicaid Agency makes a capitated payment, medical

care to Medicaid beneficiaries assigned to the integrated care network. The Medicaid Agency may enter into a contract pursuant to this section only if, in the judgment of the Medicaid Agency, care of Medicaid beneficiaries would be better, more efficient, and less costly than under the then existing care delivery system. Pursuant to the contract, the Medicaid Agency shall set capitation payments for the integrated care network.

(b) The Medicaid Agency shall enroll beneficiaries it designates into an integrated care network consistent with guidance from the Center for Medicare and Medicaid Services.

(c) An integrated care network shall provide applicable Medicaid services to Medicaid enrollees directly or by contract with other providers. An integrated care network shall establish an adequate medical service delivery network as determined by the Medicaid Agency. The Medicaid Agency, pursuant to the Administrative Procedure Act, shall establish by rule the minimum reimbursement rate for providers. The minimum provider reimbursements shall be incorporated into the actuarially sound rate development methodology for an integrated care network. If necessary, the methodology and resulting rates shall be submitted to the Centers for Medicare and Medicaid Services for approval.

Section 7. (a) The Medicaid Agency shall establish by rule procedures for safeguarding against wrongful denial of claims and addressing grievances of enrollees in an integrated care network.

(b) If a patient or the provider is dissatisfied with the decision of an integrated care network, the patient or provider may file a written notice of appeal to the Medicaid Agency. The Medicaid Agency shall adopt rules governing the appeal, which shall include a full evidentiary hearing and a finding on the record. The Medicaid Agency's decision shall be binding upon the integrated care network. However, a patient or provider may file an appeal in circuit court in the county in which the patient resides, or the county in which the provider provides services.

(c) The Medicaid Agency shall by rule establish procedures for addressing grievances and appeals of the integrated care network. The grievance procedure shall include an opportunity for a fair hearing before an impartial hearing officer in accordance with the Administrative Procedure Act, Chapter 22, Title 41, Code of Alabama 1975. The state Medicaid commissioner shall appoint one, or more than one, hearing officer to conduct fair hearings. After each hearing, the findings and recommendations of the hearing officer shall be submitted to the Commissioner, who shall make a final decision for the agency. Judicial review of the final decision of the Medicaid Agency may be sought pursuant to the Administrative Procedure Act. All costs related to development and implementation of the grievance procedure, including the provision of administrative hearings, shall be borne by the Medicaid Agency. The Medicaid Agency may adopt rules for

implementing this subsection in accordance with the Administrative Procedure Act.

Section 8. (a) All provider contracts of an organization granted final certification as an integrated care network shall be subject to review and approval of the Medicaid Agency.

(b)(1) If a provider is dissatisfied with any term or provision of the agreement or contract offered by an integrated care network, the provider shall:

a. Seek redress with the integrated care network. In providing redress, an integrated care network shall afford the provider a review by a panel composed of a representative of an integrated care network, the same type of provider, and a representative of the citizens' advisory board appointed by the chair of the advisory board.

b. After seeking redress with an integrated care network, a provider or an integrated care network who remains dissatisfied may request a review of such disputed term or provision by the Medicaid Agency. The Medicaid Agency shall have 10 days to issue, in writing, its decision regarding the dispute.

c. If the provider or an integrated care network is dissatisfied with the decision of the Medicaid Agency, the provider or an integrated care network may file an appeal in the Montgomery County Circuit Court within 30 days of the decision.

(c) The Medicaid Agency shall establish by rule requirements by which an integrated care network will operate. In addition to the foregoing, the Medicaid Agency shall do all of the following:

(1) Establish by rule the criteria for certification of an integrated care network.

(2) Establish by rule the quality standards and minimum service delivery network requirements for an integrated care network to provide care to Medicaid beneficiaries.

(3) Establish by rule and implement quality assurance provisions for an integrated care network.

(4) Adopt and implement, at its discretion, requirements for an integrated care network concerning health information technology, data analytics, quality of care, and care quality improvement.

(5) Conduct or contract for financial audits of an integrated care network. The audits shall be based on requirements established by the Medicaid Agency by rule or established by law. The audit of an integrated care network shall be conducted at least every three years or more frequently if requested by the Medicaid Agency.

(6) Take any other action with respect to an integrated care network 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 an integrated care network qualify for federal matching funds.

Section 9. (a) The Medicaid Agency shall create a quality assurance committee appointed by the Medicaid Commissioner to review the care rendered through the integrated care network. The members of the committee shall serve two-year terms. The Medicaid Agency shall promulgate a rule establishing the membership and criteria to serve on the quality assurance committee.

(b) The Medicaid Agency shall continuously evaluate the outcome and quality measures adopted by the committee pursuant to this section.

(c) The Medicaid Agency 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.

(d) The Medicaid Agency 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 all of the following:

(1) Quality measures.

(2) Costs.

(3) Outcomes.

(4) Other information, as specified by the contract between the integrated care network and the Medicaid Agency, that is necessary for the Medicaid Agency to evaluate the

value of health services delivered by an integrated care network.

Section 10. A risk contract between the Medicaid Agency and an integrated care network shall be for two years, with the option for Medicaid to renew the contract for not more than three additional one-year periods. The Medicaid Agency shall obtain provider input and an independent evaluation of the cost savings, patient outcomes, and quality of care provided by an integrated care network, and obtain the results of an integrated care network's evaluation in time to use the findings to decide whether to enter into another multi-year contract with the integrated care network or change the Medicaid care delivery system associated with an integrated care network.

Section 11. (a) The Medicaid Agency shall establish by rule the procedure for the termination of an integrated care network certification for non-performance of contractual duty or for failure to meet or maintain standards or requirements provided by this act or established by the Medicaid Agency as required by this act.

(b) Termination of an integrated care network certification shall follow the standard administrative process with the right to a hearing before a hearing officer appointed by the Medicaid Agency.

Section 12. An integrated care network shall contract with any willing nursing home, doctor, home and community waiver program or other provider to provide services

through an integrated care network if the provider is willing to accept the payments and terms offered comparable providers, where applicable, but in no event less than amounts historically paid by the Medicaid Agency to comparable providers. To the extent that the Medicaid Agency currently calculates and establishes provider-specific rates for any provider category on an annualized basis, it shall continue to calculate and establish such rates and the integrated care network shall be required to offer providers from that category not less than their established rates. 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.

Section 13. (a) The following timeline applies to implementation of this act:

(1) Not later than April 1, 2017, the Medicaid Agency shall establish integrated care network rules setting forth solvency, governing board, network, and active supervision requirements, as well as other requirements of the Medicaid Agency.

(2) Not later than April 1, 2018, Medicaid Agency will initiate competitive procurement for the services of integrated care network or networks.

(3) Not later than October 1, 2018, one or more integrated care networks certified by the Medicaid Agency shall begin to deliver services pursuant to a risk bearing contract.

Section 14. (a) The Medicaid Agency shall determine by rule which groups of Medicaid beneficiaries to include for coverage by an integrated care network. The Medicaid Agency, without the approval of the Governor, shall not make a coverage decision that would affect Medicaid beneficiaries who are directly served by another state agency.

(b) Notwithstanding subsection (a), the current Medicaid long-term care programs shall continue as currently administered by the Medicaid Agency until one or more integrated care networks are fully operational and has entered into a risk contract as provided herein.

Section 15. (a) The Legislature declares that collaboration among public payers, private health carriers, third party purchasers, and 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 act is to provide quality health care at the lowest possible cost to Alabama citizens who are Medicaid eligible. The Legislature, therefore, declares that this health care delivery system affirmatively contemplates the foreseeable displacement of competition, such that any anti-competitive effect may be attributed to the state'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 Legislature declares its intent to exempt from state anti-trust laws, and provide immunity

from federal anti-trust laws through the state action doctrine to, collaborators, regional care organizations, the integrated care networks, and contractors that are carrying out the state's policy and regulatory program of health care delivery pursuant to this act.

(b) The Medicaid Agency shall promulgate rules to carry out the provisions of this section.

(c) Collaborators shall apply with the Medicaid Agency for a certificate in order to collaborate with other entities, individuals, integrated care networks, or regional care organizations. The applicant shall describe what entities and persons with whom the applicant intends on collaborating or negotiating, the expected effects of the negotiated contract, and any other information the Medicaid Agency deems fit. The applicant shall certify that the bargaining is in good faith and necessary to meet the legislative intent stated herein. Before commencing cooperation or negotiations described in this section, an entity or individual shall possess a valid certificate.

(1) Upon a sufficient showing that the collaboration is in order to facilitate the development and establishment of an integrated care network or health care payment reforms, the Medicaid Agency shall issue a certificate allowing the collaboration.

(2) A certificate shall allow collective negotiations, bargaining, and cooperation among collaborators and the integrated care networks.

(d) All agreements and contracts of an integrated care network shall be subject to review and approval by the Medicaid Agency.

(e) If collaborators or the integrated care network are unable to reach an agreement, they may request that the Medicaid Agency intervene and facilitate negotiations.

(f) Notwithstanding any other law, the Medicaid Commissioner or any designee of the commissioner may engage in any other appropriate state supervision necessary to promote state action immunity under state and federal anti-trust laws, and may inspect or request additional documentation to verify that the Medicaid laws are implemented in accordance with the legislative intent.

(g) The Medicaid Commissioner may convene collaborators and an integrated care network to facilitate the development and establishment of an integrated care network and health care payment reforms.

(h) The Medicaid Agency 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 health care marketplace.

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

(i) To the extent the collaborators and an integrated care network are participating in good faith negotiations, cooperation, bargaining, or contracting in ways that support the intent of establishment of one or more integrated care networks or other health care payment reforms, those state-authorized collaborators and the integrated care network shall be exempt from the anti-trust 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 Medicaid Agency. 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 act shall prohibit the disclosure of any information that is required to be released to the United States government or any subdivision thereof. The Medicaid Agency, 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 Medicaid Agency shall be narrowly construed.

(k) The Medicaid Agency shall actively monitor activities and agreements approved under this act to ensure that a collaborator's or integrated care network's performance under the agreement remains in compliance with the conditions of approval. Upon request and not less than annually, a collaborator or integrated care network shall provide information regarding agreement compliance. The Medicaid Agency 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 Medicaid Agency, or presented to the Medicaid Agency, may take direct judicial appeal as provided for judicial review of final decisions in the Administrative Procedure Act.

Section 16. The Medicaid Agency may adopt rules necessary to implement this act and to administer the Medicaid Program as provided in this act in a manner consistent with state and federal law, as well as any State Plan or State Plan Waiver approved by the Centers for Medicare and Medicaid Services.

Section 17. All laws or parts of laws which conflict with this act are repealed. Notwithstanding the above, it is expressly declared that the provisions added by this act apply

only to long-term care and integrated care networks as provided for in this act. The provisions of this act shall not be construed to be in conflict with or to amend, repeal, or modify any provisions of Sections 26-6-150, 22-6-160 to 22-6-164, Code of Alabama 1975, inclusive, that do not expressly deal with long-term care, nor any laws and regulations that deal with care provided by regional care organizations or alternative care providers.

Section 18. This act shall become effective immediately following its passage and approval by the Governor, or its otherwise becoming law.