1 SB340

2 151489-6

3 By Senator Reed

4 RFD: Health

5 First Read: 14-MAR-13

1 SB340
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4 ENROLLED, An Act,
5 Relating to the Medicaid Agency; to provide for the
6 delivery of medical services to Medicaid beneficiaries on a
7 managed care basis through regional care organizations or
8 alternate care providers.
9 BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:
10 Section 1. For the purposes of this act, the
11 following words shall have the following meanings:
12 (1) ALTERNATE CARE PROVIDER. A contractor, other
13 than a regional care organization, that agrees to provide a
14 comprehensive package of Medicaid benefits to Medicaid
15 beneficiaries in a defined region of the state pursuant to a
16 risk contract.
17 (2) CAPITATION PAYMENT. A payment the state Medicaid
18 Agency makes periodically to a contractor on behalf of each
19 recipient enrolled under a contract for the provision of
20 medical services.
21 (3) CARE DELIVERY SYSTEM. The manner in which the
22 benefits and services set forth in the state Medicaid plan are
23 provided to Medicaid beneficiaries.
24 (4) COLLABORATOR. A private health carrier, third
25 party purchaser, provider, health care center, health care

1 facility, state and local governmental entity, or other public
2 payers, corporations, individuals, and consumers who are
3 expecting to collectively cooperate, negotiate, or contract
4 with another collaborator or regional care organizations in
5 the health care system.
6 (5) LONG-TERM CARE. Medicaid-funded nursing facility
7 services or services in intermediate care facilities for the
8 developmentally disabled, or home- and community-based support
9 services provided to individuals who might otherwise require
10 such services, or such other long-term care services as the
11 Medicaid Agency may determine by rule.
12 (6) MEDICAID AGENCY. The Alabama Medicaid Agency or
13 any successor agency of the state designated as the "single
14 state agency" to administer the medical assistance program
15 described in Title XIX of the Social Security Act.
16 (7) MEDICAID BENEFICIARY. Anyone determined by the
17 Medicaid Agency to be eligible for Medicaid.
18 (8) QUALITY-ASSURANCE PROVISIONS. Specifications for
19 assessing and improving the quality of care provided by a
20 regional care organization or an alternative care plan.
21 (9) REGIONAL CARE ORGANIZATION. An organization of
22 health care providers that contracts with the Medicaid Agency
23 to provide a comprehensive package of Medicaid benefits to
24 Medicaid beneficiaries in a defined region of the state and
25 that meets the requirements set forth in this act.

1 (10) RISK CONTRACT. A contract under which the
2 contractor assumes risk for the cost of the services covered
3 under the contract and incurs loss if the cost of furnishing
4 the services exceeds the payments under the contract.
5 Section 2. (a) A regional care organization shall
6 serve only Medicaid beneficiaries in providing medical care
7 and services.
8 (b) Notwithstanding any other provision of law, a
9 regional care organization shall not be deemed an insurance
10 company under state law.
11 (c)(1) A regional care organization and an
12 organization with probationary regional care organization
13 certification shall have a governing board of directors
14 composed of the following members:
15 a. Twelve members shall be persons representing
16 risk-bearing participants in the regional care organization or
17 organization with probationary certification. A participant
18 bears risk by contributing cash, capital, or other assets to
19 the regional care organization. A participant also bears risk
20 by contracting with the regional care organization to treat
21 Medicaid beneficiaries at a capitated rate per beneficiary or
22 to treat Medicaid beneficiaries even if the regional care
23 organization does not reimburse the participant.
24 b. Eight members shall be persons who do not
25 represent a risk-bearing participant in the regional care

1 organization. Of these eight members, five members shall be
2 medical professionals who provide care to Medicaid
3 beneficiaries in the region. Three of these members shall be
4 primary care physicians, one an optometrist, and one a
5 pharmacist. One primary care physician shall be from a
6 Federally Qualified Health Center appointed jointly by the
7 Alabama Primary Health Care Association and the Alabama
8 Chapter of the National Medical Association and the other two
9 primary care physicians shall be appointed by a caucus of
10 county boards of health in the region. The optometrist shall
11 be appointed by the Alabama Optometric Association, or its
12 successor organization. The pharmacist shall be appointed by
13 the Alabama Pharmacy Association, or its successor
14 organization. All five medical professionals shall work in the
15 region served by the regional care organization. None of these
16 members shall be a risk-bearing participant in the regional
17 care organization or be an employee of a risk-bearing
18 participant, but these members may contract with the regional
19 care organization on a fee-for-service basis.
20 c. Three members shall be community representatives
21 as follows: 1. The chair of the citizens' advisory committee
22 established pursuant to subsection (d). 2. Another citizens'
23 advisory committee member, elected by the committee, who is a
24 representative of an organization that is part of the
25 Disabilities Leadership Coalition of Alabama or Alabama Arise,

1 or their successor organizations. 3. A business executive,
2 nominated by a chamber of commerce in the region, who works in
3 the region. These members may not be risk-bearing participants
4 in the regional care organization or employees of a
5 risk-bearing participant.

6 (2) A majority of the members of the board may not
7 represent a single type of provider, such as hospitals or
8 doctors engaged in medical practice.

9 (3) The Medicaid Agency shall have the power to
10 approve the members of the governing board and the board's
11 structure, powers, bylaws, or other rules of procedure. No
12 organization shall be granted probationary regional care
13 organization certification or full regional care organization
14 certification without approval.

15 (4) The regional care organization, the caucus of
16 county boards of health in the region, the citizens' advisory
17 committee, and the optometric, and pharmacy associations shall
18 promptly fill any vacancy on the board of directors.
19 Notwithstanding other provisions of this subsection, the
20 Medicaid Commissioner shall fill a board seat left vacant for
21 at least three months.

22 (5) The governing board may not take any action
23 unless at least one physician appointed by a caucus of county
24 boards of health in the region, who does not represent a
25 risk-bearing participant and who does not hold one of the

1 three seats held by community representatives, votes on the
2 prevailing side.
3 (6) The membership of the governing board of
4 directors shall be inclusive and reflect the racial, gender,
5 geographic, urban/rural and economic diversity of the region.
6 (d) A citizen's advisory committee shall advise the
7 organization on ways the organization may be more efficient in
8 providing quality care to Medicaid beneficiaries. In addition,
9 an advisory committee shall carry out other functions and
10 duties assigned to it by a regional care organization and
11 approved by the Medicaid Agency. Each regional care
12 organization shall have a citizens' advisory committee, as
13 shall an organization seeking to become a regional care
14 organization, which membership shall be inclusive and reflect
15 the racial, gender, geographic, urban/rural, and economic
16 diversity of the state. The committee shall meet all of the
17 following criteria:
18 (1) Be selected in a method established by the
19 organization seeking to become a regional care organization,
20 or established by the regional care organization, and approved
21 by the Medicaid Agency.
22 (2) At least 20 percent of its members shall be
23 Medicaid beneficiaries or, if the organization has been
24 certified as a regional care organization, at least 20 percent

1 of its members shall be Medicaid beneficiaries enrolled in the
2 regional care organization.
3 (3) Include members who are representatives of
4 organizations that are part of the Disabilities Leadership
5 Coalition of Alabama or Alabama Arise, or their successor
6 organizations.
7 (4) Include only persons who live in the Medicaid
8 region the organization plans to serve; or if the organization
9 has become a regional care organization, include only persons
10 who live in the Medicaid region served by the regional care
11 organization. The membership of the committee shall be
12 inclusive and reflect the racial, gender, geographic,
13 urban/rural and economic diversity of the region.
14 (5) Elect a chair.
15 (6) Meet at least every three months.
16 (e)(1) Each regional care organization shall meet
17 minimum solvency and financial requirements as provided in
18 this subsection. The Medicaid Agency shall require a regional
19 care organization, as a condition of certification or
20 continued certification, to maintain minimum financial
21 reserves at the following levels:
22 a. Restricted reserves of two hundred fifty thousand
23 dollars ($250,000) or an amount equal to 25 percent of the
24 regional care organization's total actual or projected average
25 monthly expenditures, whichever is greater.

1 b. Capital or surplus, or any combination thereof,
2 of two million five hundred thousand dollars ($2,500,000).
3 (2) Instead of maintaining the financial reserves
4 required in subdivision (1), a regional care organization that
5 has entered into a risk contract with the Medicaid Agency may
6 submit to the agency a written guaranty in the form of a bond
7 issued by an insurer, in an amount equal to the financial
8 reserves that would otherwise be required of the regional care
9 organization under subdivision (1), to guarantee the
10 performance of the provisions of the risk contract. The bond
11 shall be issued by an insurer authorized in this state and
12 approved by the Medicaid Commissioner. No assets of the
13 regional care organization shall be pledged or encumbered for
14 the payment of the performance bond.
15 (f) A regional care organization shall provide such
16 financial reports and information as required by the Medicaid
17 Agency.
18 (g) A regional care organization shall report all
19 data as required by the Medicaid Agency, consistent with the
20 federal Health Insurance Portability and Accountability Act
21 (HIPAA).
22 Section 3. The Medicaid Agency shall establish by
23 rule geographic Medicaid regions in which a regional care
24 organization or alternate care provider may operate, which
25 together shall cover the entire state. Each Medicaid region,

1 according to an actuary working for Medicaid, shall be capable
2 of supporting at least two regional care organizations or
3 alternate care providers.
4 Section 4. (a) Subject to approval of the federal
5 Centers for Medicare and Medicaid Services, the Medicaid
6 Agency shall enter into a contract in each Medicaid region for
7 at least one fully certified regional care organization to
8 provide, pursuant to a risk contract under which the Medicaid
9 Agency makes a capitated payment, medical care to Medicaid
10 beneficiaries. However, the Medicaid Agency may enter into a
11 contract pursuant to this section only if, in the judgment of
12 the Medicaid Agency, care of Medicaid beneficiaries would be
13 better, more efficient, and less costly than under the then
14 existing care delivery system. The Medicaid Agency may
15 contract with more than one regional care organization in a
16 Medicaid region. Pursuant to the contract, the Medicaid Agency
17 shall set capitation payments for the regional care
18 organization.
19 (b) The Medicaid Agency shall enroll beneficiaries
20 into regional care organizations. If more than one regional
21 care organization operates in a Medicaid region, a Medicaid
22 beneficiary may choose the organization to provide his or her
23 care. If a Medicaid beneficiary does not make a choice, the
24 Medicaid Agency shall assign the person to a care

1 organization. Medicaid may limit the circumstances under which
2 a Medicaid beneficiary may change care organizations.
3 (c) A regional care organization shall provide
4 Medicaid services to Medicaid enrollees directly or by
5 contract with other providers. The regional care organization
6 shall establish an adequate medical service delivery network
7 as determined by the Medicaid Agency. An alternate care
8 provider contracting with Medicaid shall also establish such a
9 network.
10 (d) The Medicaid Agency shall establish by rule
11 procedures for safeguarding against wrongful denial of claims
12 and addressing grievances of enrollees in a regional care
13 organization or an alternate care provider. The procedures
14 shall provide for a timely and meaningful right of appeal, by
15 Medicaid enrollees or their providers, of approvals or denials
16 of care, billing and payment issues, bundling matters, and the
17 provision of health care services. The rules shall include
18 procedures for a fair hearing on all claims or complaints
19 brought by Medicaid enrollees or other providers that shall
20 include the following:
21 (1) An immediate appeal to the medical director of
22 the regional care organization, who shall be a primary care
23 physician. The rules of evidence shall not apply. The medical
24 director shall consider the materials submitted on the issue
25 and any oral arguments and render a decision. The medical

1 director's decision shall be binding on the regional care
2 organization.
3 (2) If a patient or provider is dissatisfied with
4 the decision of the medical director, the patient or physician
5 may file a notice of appeal to be heard by a peer review
6 committee. The peer review committee shall be composed of at
7 least three physicians of the same specialty in the region in
8 which the services or matter is at issue. If three physicians
9 cannot be found, then the physicians may be selected outside
10 of the region. The Medicaid Agency shall develop rules
11 regarding the appeal to the peer review committee. The peer
12 review committee's decision shall be binding on the regional
13 care organization.
14 (3) If a patient or the provider is dissatisfied
15 with the decision of the peer review committee, the patient or
16 provider may file a written notice of appeal to the Medicaid
17 Agency. The Medicaid Agency shall adopt rules governing the
18 appeal, which shall include a full evidentiary hearing and a
19 finding on the record. The Medicaid Agency's decision shall be
20 binding upon the regional care organization. However, a
21 patient or provider may file an appeal in circuit court in the
22 county in which the patient resides, or the county in which
23 the provider provides services.
24 (e) The Medicaid Agency shall by rule establish
25 procedures for addressing grievances of regional care

1 organizations. The grievance procedure shall include an
2 opportunity for a fair hearing before an impartial hearing
3 officer in accordance with the Alabama Administrative
4 Procedure Act, Chapter 22, Title 41, Code of Alabama 1975. The
5 state Medicaid commissioner shall appoint one, or more than
6 one, hearing officer to conduct fair hearings. After each
7 hearing, the findings and recommendations of the hearing
8 officer shall be submitted to the commissioner, who shall make
9 a final decision for the agency. Judicial review of the final
10 decision of the Medicaid Agency may be sought pursuant to the
11 Alabama Administrative Procedure Act. All costs related to
12 development and implementation of the grievance procedure,
13 including the provision of administrative hearings, shall be
14 borne by the Medicaid Agency. The agency may adopt rules for
15 implementing this subsection in accordance with the Alabama
16 Administrative Procedure Act.
17 (f) In addition to the foregoing, the Medicaid
18 Agency shall do all of the following:
19 (1) Establish by rule the criteria for probationary
20 and full certification of regional care organizations.
21 (2) Establish the quality standards and minimum
22 service delivery network requirements for regional care
23 organizations or alternate care providers to provide care to
24 Medicaid beneficiaries.

1 (3) Establish by rule and implement quality
2 assurance provisions for each regional care organization.
3 (4) Adopt and implement, at its discretion,
4 requirements for a regional care organization concerning
5 health information technology, data analytics, quality of
6 care, and care-quality improvement.
7 (5) Conduct or contract for financial audits of each
8 regional care organization. The audits shall be based on
9 requirements established by the Medicaid Agency by rule or
10 established by law. The audit of each regional care
11 organization shall be conducted at least every three years or
12 more frequently if requested by the Medicaid Agency.
13 (6) Take such other action with respect to regional
14 care organizations or alternate care providers as may be
15 required by federal Medicaid regulations or under terms and
16 conditions imposed by the Centers for Medicare and Medicaid
17 Services in order to assure that payments to the regional care
18 organizations or alternate care providers qualify for federal
19 matching funds.
20 Section 5. (a) The Medicaid Agency shall create a
21 quality assurance committee appointed by the Medicaid
22 Commissioner. The members of the committee shall serve
23 two-year terms. At least 60 percent of the members shall be
24 physicians who provide care to Medicaid beneficiaries served
25 by a regional care organization. In making appointments to the

1 committee, the Medicaid Commissioner shall seek input from the
2 appropriate professional associations.
3 (b) The committee shall identify objective outcome
4 and quality measures, including measures of outcome and
5 quality for ambulatory care, inpatient care, chemical
6 dependency and mental health treatment, oral health care, and
7 all other health services provided by coordinated care
8 organizations. Quality measures adopted by the committee shall
9 be consistent with existing state and national quality
10 measures. The Medicaid Commissioner shall incorporate these
11 measures into regional care organization contracts to hold the
12 organizations accountable for performance and customer
13 satisfaction requirements.
14 (c) The committee shall adopt outcome and quality
15 measures annually and adjust the measures to reflect the
16 following:
17 (1) The amount of the global budget for a regional
18 care organization.
19 (2) Changes in membership of the organization.
20 (3) The organization's costs for implementing
21 outcome and quality measures.
22 (4) The community health assessment and the costs of
23 the community health assessment conducted by the organization.

1 (d) The Medicaid Agency shall continuously evaluate
2 the outcome and quality measures adopted by the committee
3 pursuant to this section.
4 (e) The Medicaid Agency shall utilize available data
5 systems for reporting outcome and quality measures adopted by
6 the committee and take actions to eliminate any redundant
7 reporting or reporting of limited value.
8 (f) The Medicaid Agency shall publish the
9 information collected under this section at aggregate levels
10 that do not disclose information otherwise protected by law.
11 The information published shall report, by regional care
12 organizations, all of the following:
13 (1) Quality measures.
14 (2) Costs.
15 (3) Outcomes.
16 (4) Other information, as specified by the contract
17 between the regional care organization and the Medicaid
18 Agency, that is necessary for the Medicaid Agency to evaluate
19 the value of health services delivered by a regional care
20 organization.
21 Section 6. An initial contract between the Medicaid
22 Agency and a regional care organization shall be for three
23 years, with the option for Medicaid to renew the contract for
24 not more than two additional one-year periods. The Medicaid
25 Agency shall obtain an independent evaluation of the cost

1 savings, patient outcomes, and quality of care provided by
2 each regional care organization, and obtain the results of
3 each regional care organization's evaluation in time to use
4 the findings to decide whether to enter into another
5 multi-year contract with the regional care organization or
6 change the Medicaid region's care-delivery system.
7 Section 7. The Medicaid Agency may contract with an
8 alternate care provider in a Medicaid region only under the
9 terms of this section:
10 (a) If a regional care organization failed to
11 provide adequate service pursuant to its contract, or had its
12 certification terminated, or if the Medicaid Agency could not
13 award a contract to a regional care organization under the
14 terms of Section 4, or if no organization had been awarded a
15 regional care organization certificate by October 1, 2016,
16 then the Medicaid Agency shall first offer a contract, to
17 resume interrupted service or to assume service in the region,
18 under the conditions of Section 4 to any other regional care
19 organization that Medicaid judged would meet its quality
20 criteria.
21 (b) If by October 1, 2014, no organization had a
22 probationary regional care organization certification in a
23 region. However, the Medicaid Agency could extend the deadline
24 until January 1, 2015, if it judged an organization was making
25 reasonable progress toward getting probationary certification.

1 If Medicaid judged that no organization in the region likely
2 would achieve probationary certification by January 1, 2015,
3 then the Medicaid Agency shall let any organization with
4 probationary or full regional care organization certification
5 apply to develop a regional care organization in the region.
6 If at least one organization made such an application, the
7 agency no sooner than October 1, 2015, would decide whether
8 any organization could reasonably be expected to become a
9 fully certified regional care organization in the region and
10 its initial region.
11 (c) If an organization lost its probationary
12 certification before October 1, 2016, Medicaid shall offer any
13 other organization with probationary or full regional care
14 organization certification, which it judged could successfully
15 provide service in the region and its initial region, the
16 opportunity to serve Medicaid beneficiaries in both regions.
17 (d) Medicaid may contract with an alternate care
18 provider only if no regional care organization accepted a
19 contract under the terms of (a), or no organization was
20 granted the opportunity to develop a regional care
21 organization in the affected region under the terms of (b), or
22 no organization was granted the opportunity to serve Medicaid
23 beneficiaries under the terms of (c).
24 (e) The Medicaid Agency may contract with an
25 alternate care provider under the terms of subsection (d) only

1 if, in the judgment of the Medicaid Agency, care of Medicaid
2 enrollees would be better, more efficient, and less costly
3 than under the then existing care delivery system. Medicaid
4 may contract with more than one alternate care provider in a
5 Medicaid region.
6 Section 8. (a) The Medicaid Agency shall establish
7 by rule the procedure for the termination of a regional care
8 organization certification or probationary regional care
9 organization certification for non-performance of contractual
10 duty or for failure to meet or maintain benchmarks, standards,
11 or requirements provided by this act or established by the
12 Medicaid Agency as required by this act.
13 (b) Termination of a regional care organization
14 certification or probationary certification shall follow the
15 standard administrative process, with the right to a hearing
16 before a hearing officer appointed by the Medicaid Agency.
17 Section 9. A regional care organization shall
18 contract with any willing hospital, doctor, or other provider
19 to provide services in a Medicaid region if the provider is
20 willing to accept the payments and terms offered comparable
21 providers. Any provider shall meet licensing requirements set
22 by law, shall have a Medicaid provider number, and shall not
23 otherwise be disqualified from participating in Medicare or
24 Medicaid.

1 Section 10. (a) The following is the timeline for
2 implementation of this act:
3 (1) Not later than October 1, 2013, the Medicaid
4 Agency shall establish Medicaid regions.
5 (2) Not later than October 1, 2014, an organization
6 seeking to become a regional care organization shall have
7 established a governing board and structure as approved by the
8 Medicaid Agency. An organization may receive probationary
9 certification as a regional care organization upon submission
10 of an application for, and demonstration of, a governing board
11 acceptable to the Medicaid Agency. Probationary certification
12 shall expire no later than October 1, 2016.
13 (3) Not later than April 1, 2015, an organization
14 with probationary regional care organization certification
15 shall have demonstrated to Medicaid's approval the ability to
16 establish an adequate medical service delivery network.
17 (4) Not later than October 1, 2015, an organization
18 with probationary regional care organization certification
19 shall have demonstrated to Medicaid's approval that it has met
20 the solvency and financial requirements for a regional care
21 organization as outlined in this act.
22 (5) Not later than October 1, 2016, an organization
23 with probationary regional care organization certification
24 shall demonstrate to Medicaid's approval that it is capable of
25 providing services pursuant to a risk contract.

1 (b) The timeline and benchmarks in subsection (a)
2 shall not preclude an organization from meeting the timelines
3 and benchmarks at an earlier date.
4 (c) Failure to meet and maintain any one of the
5 benchmarks in subdivisions (2) to (5), inclusive, shall
6 constitute grounds for termination of a probationary regional
7 care organization certification or full regional care
8 organization certification. The Medicaid Agency shall award
9 full regional care organization certification to an
10 organization with probationary regional care organization
11 certification if the organization timely meets each of those
12 benchmarks. Failure by an organization to timely meet one or
13 more of those benchmarks shall not prevent the Medicaid
14 Agency, at its sole discretion, from granting full regional
15 care organization certification to the organization as long as
16 it has met all of those benchmarks by October 1, 2016.
17 Section 11. (a) The Medicaid Agency, with input from
18 long-term care providers, shall conduct an evaluation of the
19 existing long-term care system for Medicaid beneficiaries and,
20 on October 1, 2015, shall report the findings of the
21 evaluation to the Legislature and Governor.
22 (b) The Medicaid Agency shall decide which groups of
23 Medicaid beneficiaries to include for coverage by a regional
24 care organization or alternate care provider. The Medicaid
25 Agency, without the approval of the Governor, shall not make a

1 coverage decision that would affect Medicaid beneficiaries who
2 are directly served by another state agency.
3 (c) Notwithstanding the above, the current Medicaid
4 long-term care programs shall continue as currently
5 administered by the Medicaid Agency until the end of the
6 fiscal year when the evaluation required in subsection (a) is
7 reported to the Legislature and the Governor.
8 Section 12. (a) The Medicaid Agency, with input from
9 dental care providers, shall conduct an evaluation of the
10 existing dental care program for Medicaid beneficiaries and,
11 on October 1, 2015, shall report the findings of the
12 evaluation to the Legislature and Governor.
13 (b) Notwithstanding the above, the current Medicaid
14 dental care programs shall continue as currently administered
15 by the Medicaid Agency until the end of the fiscal year when
16 the evaluation required in subsection (a) is reported to the
17 Legislature and the Governor.
18 Section 13. The Medicaid Agency may contract for
19 case-management services with an organization that has been
20 granted by the Medicaid Agency a probationary regional care
21 organization certification. If the agency has contracted with
22 such an organization, and that organization on or before
23 October 1, 2016, has failed to gain full regional care
24 organization certification or has had its probationary
25 certification terminated, then that organization shall refund

1 half the payments, made by the Medicaid Agency to the
2 organization for case-management services, paid over the
3 previous 12 months.
4 Section 14. (a) The Legislature declares that
5 collaboration among public payers, private health carriers,
6 third party purchasers, and providers to identify appropriate
7 service delivery systems and reimbursement methods in order to
8 align incentives in support of integrated and coordinated
9 health care delivery is in the best interest of the
10 public. Collaboration pursuant to this act is to provide
11 quality health care at the lowest possible cost to Alabama
12 citizens who are Medicaid eligible. The Legislature,
13 therefore, declares that this health care delivery system
14 affirmatively contemplates the foreseeable displacement of
15 competition, such that any anti-competitive effect may be
16 attributed to the state's policy to displace competition in
17 the delivery of a coordinated system of health care for the
18 public benefit. In furtherance of this goal, the Legislature
19 declares its intent to exempt from state anti-trust laws, and
20 provide immunity from federal anti-trust laws through the
21 state action doctrine to, collaborators, regional care
22 organizations, and contractors that are carrying out the
23 state's policy and regulatory program of health care delivery.
24 (b) The Medicaid Agency shall adopt rules to carry
25 out the provisions of this section.

1 (c) Collaborators shall apply with the Medicaid
2 Agency for a certificate in order to collaborate with other
3 entities, individuals, or regional care organizations. The
4 applicant shall describe what entities and persons with whom
5 the applicant intends on collaborating or negotiating, the
6 expected effects of the negotiated contract, and any other
7 information the Medicaid Agency deems fit. The applicant shall
8 certify that the bargaining is in good faith and necessary to
9 meet the legislative intent stated herein. Before commencing
10 cooperation or negotiations described in this section, an
11 entity or individual shall possess a valid certificate.
12 (1) Upon a sufficient showing that the collaboration
13 is in order to facilitate the development and establishment of
14 the regional care organization or health care payment reforms,
15 the Medicaid Agency shall issue a certificate allowing the
16 collaboration.
17 (2) A certificate shall allow collective
18 negotiations, bargaining, and cooperation among collaborators
19 and regional care organizations.
20 (d) All agreements and contracts shall be approved
21 by the Medicaid Commissioner.
22 (e) Should collaborators or a regional care
23 organization be unable to reach an agreement, they may request
24 that the Medicaid Agency intervene and facilitate
25 negotiations.

1 (f) Notwithstanding any other law, the Medicaid
2 Commissioner or the commissioner's designee may engage in any
3 other appropriate state supervision necessary to promote state
4 action immunity under state and federal anti-trust laws, and
5 may inspect or request additional documentation to verify that
6 the Medicaid laws are implemented in accordance with the
7 legislative intent.
8 (g) The Medicaid Commissioner may convene
9 collaborators and regional care organizations to facilitate
10 the development and establishment of the regional care
11 organizations and health care payment reforms. Any
12 participation by such entities and individuals shall be on a
13 voluntary basis.
14 (h) The Medicaid Agency may do any or all of the
15 following:
16 (1) Conduct a survey of the entities and individuals
17 concerning payment and delivery reforms.
18 (2) Collect information from other persons to assist
19 in evaluating the impact of any proposed agreement on the
20 health care marketplace.
21 (3) Convene meetings at a time and place that is
22 convenient for the entities and individuals.
23 (i) To the extent the collaborators and regional
24 care organizations are participating in good faith
25 negotiations, cooperation, bargaining, or contracting in ways

1 that support the intent of establishment of the regional care
2 organization or other health care payment reforms, those
3 state-authorized collaborators and regional care organizations
4 shall be exempt from the anti-trust laws under the state
5 action immunity doctrine.
6 (j) All reports, notes, documents, statements,
7 recommendations, conclusions, or other information submitted
8 pursuant to this section, or created pursuant to this section,
9 shall be privileged and confidential, and shall only be used
10 in the exercise of the proper functions of the Medicaid
11 Agency. These confidential records shall not be public records
12 and shall not be subject to disclosure except under HIPAA. Any
13 information subject to civil discovery or production shall be
14 protected by a confidentiality agreement or order. Nothing
15 contained herein shall apply to records made in the ordinary
16 course of business of an individual, corporation, or entity.
17 Documents otherwise available from original sources are not to
18 be construed as immune from discovery or used in any civil
19 proceedings merely because they were submitted pursuant to
20 this section. Nothing in this subsection or act shall apply to
21 prohibit the disclosure of any information that is required to
22 be released to the United States government or any subdivision
23 thereof. The Medicaid Agency, in its sole discretion, but with
24 input from potential collaborators, may promulgate rules to
25 make limited exceptions to this immunity and confidentiality

1 for the disclosure of information. The exceptions created by
2 the Medicaid Agency shall be narrowly construed.
3 (k) The Medicaid Agency shall actively monitor
4 agreements approved under this act to ensure that a
5 collaborator's or regional care organization's performance
6 under the agreement remains in compliance with the conditions
7 of approval. Upon request and not less than annually, a
8 collaborator or regional care organization shall provide
9 information regarding agreement compliance. The Medicaid
10 Agency may revoke the agreement upon a finding that
11 performance pursuant to the agreement is not in substantial
12 compliance with the terms of the contract. Any entity or
13 individual aggrieved by any final decision regarding contracts
14 under this section that are approved by the Medicaid Agency,
15 or presented to the Medicaid Agency, may take direct judicial
16 appeal as provided for judicial review of final decisions in
17 the Administrative Procedure Act.
18 Section 15. The Medicaid Agency may adopt rules
19 necessary to implement this act.
20 Section 16. All laws or parts of laws which conflict
21 with this act are repealed.
22 Section 17. This act shall become effective
23 immediately following its passage and approval by the
24 Governor, or its otherwise becoming law.

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3 ____
4 President and Presiding Officer of the Senate

5 ____
6 Speaker of the House of Representatives

7 SB340
8 Senate 25-APR-13
9 I hereby certify that the within Act originated in and passed
10 the Senate, as amended.
11
12 Patrick Harris
13 Secretary
14
15

16
17 House of Representatives
18 Passed: 07-MAY-13
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21 By: Senator Reed