COMMITTEE SUBSTITUTE

FOR

H. B. 4438

(BY DELEGATES PERDUE, PERRY, HAMILTON, HARTMAN, POORE, D. CAMPBELL, M. POLING, HATFIELD, ELLINGTON, HUNT AND WILLIAMS)

(Originating in the Committee on Finance)
[February 24, 2012]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §16-2L-1, §16-2L-2, §16-2L-3, §16-2L-4, §16-2L-5, §16-2L-6, §16-2L-7, §16-2L-8, §16-2L-9, §16-2L-10, §16-2L-11, §16-2L-12, §16-2L-13 and §16-2L-14, all relating to creating the Provider Sponsored Network Act; stating the purpose; making legislative findings; defining terms; describing the services to be performed and programs to be undertaken by a provider sponsored network; authorizing the Secretary of the Department of Health and Human Resources to recognize provider sponsored networks;

assigning medicaid beneficiaries to a provider sponsored network; authorizing the Secretary of the Department of Health and Human Resources to contract with a provider sponsored network; providing for payment for services provided by a provider sponsored network; providing for participation of health care providers in a provider sponsored network; providing an exemption from anti-trust laws; addressing business and insurance risk; addressing insurance regulation of provider sponsored networks; requiring studies and reports; providing for shared savings with the state and defining the shared amounts; providing minimum capital and surplus amounts; requiring that the designation of provider sponsored networks be an open application process; providing rule-making authority and providing that reimbursement for reasonable costs will be paid by the network.

Be it enacted by the Legislature of West Virginia:

That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new article, designated §16-2L-1, §16-2L-2, §16-2L-3, §16-2L-4, §16-2L-5, §16-2L-6, §16-2L-7, §16-2L-8,

§16-2L-9, §16-2L-10, §16-2L-11, §16-2L-12, §16-2L-13 and §16-2L-14, all to read as follows:

ARTICLE 2L. PROVIDER SPONSORED NETWORKS.

§16-2L-1. Short title.

This article shall be known as the "Provider Sponsored Network Act."

§16-2L-2. Purpose.

The Legislation authorizes the secretary of the Department of Health and Human Resources to directly contract with provider sponsored networks to:

(1) Develop a direct collaborative managed care relationship with the department, its Bureau for Medical Services and providers of medical care to Medicaid enrollees;

(2) Create a new health care choice, a provider sponsored network program, for Medicaid enrollees; and

(3) Implement innovative provider sponsored network health care management approaches in order to improve Medicaid enrollee health outcomes;

(4) Remove barriers to establishing alternate forms of care management by and with providers directly responsible for care by promoting shared use of patient-centered medical home resources among mission based and privately practicing health care providers, and exempting these providers from anti-trust and insurance regulation with respect to provider sponsored network initiatives;

(5) Create opportunities for the state to constrain the rise in the cost of health care provided to Medicaid enrollees, share in savings, and to enhance access to care for Medicaid enrollees by supporting the existing health delivery efficiencies offered by provider sponsored network providers; and

(6) Encourage privately practicing physicians and other provider participation in provider sponsored networks by reducing the administrative burdens and the expense of compliance with Medicaid program requirements and by allowing provider sponsored networks to provide administrative and care management services to its providers for the coordination of patient care.

§16-2L-3. Legislative findings.

The Legislature finds:

(1) The health care delivery system and the state's budget are vulnerable to being overwhelmed by the additional demand occasioned by the expansion of persons to be served by Medicaid programs.

(2) The health of the state's Medicaid beneficiaries and the integrity of the state's fiscal budgetary operations compel the prompt pursuit of additional options to arranging for and providing health care to Medicaid populations.

(3) It inures to the benefit of the state and its Medicaid populations to foster the development of care systems and Medicaid options which allow for the functional integration or participation of privately practicing physicians with provider sponsored networks who have patient-centered medical home resources and who are willing to share access and use of those resources.

(4) Privately practicing physicians provide indispensable and important health care services to Medicaid enrollees in

West Virginia but many do not have the resources to develop patient-centered medical homes in their respective practices.

(5) Federally Qualified Health Centers lead the development and implementation of recognized medical homes in West Virginia.

(6) Better health outcomes can be achieved and inappropriate utilization avoided through the integration and coordination of physical health care with mental health care.

(7) Federally Qualified Health Centers are deeply engaged with integrating behavioral health providers and other community services in their care of Medicaid beneficiaries.

(8) The United States Congress determined in 1997 that managed care organizations which are, or are controlled by, Federally Qualified Health Centers merit special status.

(9) Provider sponsored networks working collaboratively with the Department of Health and Human Resources and its Bureau for Medical Services to improve Medicaid programs,

will provide fiscal stability for both the state and Federally Qualified Health Centers.

§16-2L-4. Definitions.

As used in this article and unless the context requires otherwise:

(1) "Patient-centered medical home" means a health care setting as identified in section nine, article twenty-nine-h, chapter sixteen of this code.

(2) "Continuity-of-care" means the clinical practice of a medical professional who provides care to patients over continuous time in which:

(A) Preventive care and counseling are provided and a patient's overall health status is monitored even when illness is not present or not in crisis in addition to episodic or urgent care provided from time to time as needed;

(B) The medical professional utilizes medical records and care processes which track and manage health status over time and are not limited to discrete episodes of care; and

(C) The records and processes described in paragraph (b) allow the medical professional to refer care to, and receive reports from, other medical professionals and other care team members responsible for the care of a particular patient.

(3) "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 U.S.C. §1396d(l)(2)(B), enacted in 1989.

(4) "Medicaid beneficiary" or "Medicaid enrollee" means any person participating in, or eligible to participate in, any Medicaid program administered by the Department of Health and Human Resources or its Bureau for Medical Services.

(5) "Medical home" means a team-based model of care in a patient-centered medical home.

(6) "Participating physician provider" means and includes any willing clinical provider in good standing with his or her professional licensing body who has been credentialed by a provider sponsored network and who agrees to participate in a provider sponsored network program.

(7) "Primary care provider" means a medical professional licensed as an allopathic or osteopathic physician primarily practicing internal medicine, family or general practice, pediatrics, obstetrics & gynecology who provides continuity-of-care services to the majority of his, her or its patients, or a licensed behavioral medicine professional who provides continuity-of-care services to the majority of his, her or its patients.

(8) "Provider sponsored network" means and includes an at-risk model or shared-savings model:

(A) A "provider sponsored network - risk" means an entity that:

(i) Satisfies the definition of a "Medicaid managed care organization" pursuant to 42 U.S.C. §1396b(m)(1)(A), enacted in 1997;

(ii) Meets the requirements of 42 U.S.C. §1396b(m)(1)(C)(ii)(IV), enacted in 1997, as an organization that is, or is controlled by, one or more Federally Qualified Health Centers; and

(iii) Meets the solvency standards for these organizations established in this article.

(B) A "provider sponsored network - shared savings" means an entity that:

(i) Meets the definition of a primary care case manager pursuant to 42 U.S.C. §1396d(t)(2);

(ii) Provides enhanced primary care case management in addition to contracting with primary care providers for primary care management;

(iii) Meets the requirements of 42 U.S.C. §1396b(m)(1)(C)(ii)(IV), enacted in 1997, as an organization that is, or is controlled by, one or more Federally Qualified Health Centers; and

(iv) Meets the solvency standards for these organizations established in this article.

(9) "Provider sponsored network program" means a program of coordinated care for Medicaid enrollees, arranged by a provider sponsored network under contract with the Department of Health and Human Resources and its Bureau

for Medical Services, using the principles of medical homes with incentives aligned with the objectives of Medicaid programs and improved and efficient health outcomes.

(10) "Secretary" means the Secretary of the Department of Health and Human Resources.

§16-2L-5. Provider sponsored network services.

(a) The provider sponsored network shall arrange for and coordinate care for existing Medicaid beneficiary patients of a provider sponsored network's participating primary care providers as assigned to them by the secretary. Neither the provider sponsored network nor any of its individual constituent health care providers are liable for care costs incurred by health care providers or suppliers who are not physically located in the provider sponsored network service area or who are not participants in the provider sponsored network except as authorized by a provider sponsored network for the Medicaid enrollees assigned by the secretary to it.

(b) A provider sponsored network program may develop and arrange for health care to be delivered to enrollees of any

Medicaid program authorized by the West Virginia Department of Health and Human Resources or its Bureau for Medical Services and be paid pursuant to terms and conditions consistent with this article.

(c) The provider sponsored network and the Bureau for Medical Services of the Department of Health and Human Resources shall work collaboratively to design benefit plans and care coordination practices regarding the operation of the provider sponsored network program. The provider sponsored network shall support and participate in health care delivery improvements and initiatives that may be piloted or established by the secretary including Medicaid health homes for patients with chronic conditions.

(d) The provider sponsored network and its constituent health care providers are expected to provide a substantial portion of the health care items and services required directly through the provider sponsored network participating providers.

(e) A provider sponsored network may, in addition to directly providing care through its participating providers,

arrange for services or care to be provided by entities other than the provider sponsored network: *Provided*, That the payment obligation, and the associated risk, is ultimately borne by the state and not the provider sponsored network. The provider sponsored network may coordinate care, process authorizations and claims for services outside of the provider sponsored network's service area and for non-provider sponsored network services and make payments in behalf of the state and to account for the same in reports to the secretary. The payment obligation of the provider sponsored network for services it authorizes to be provided by non-provider sponsored network providers or by out-of-area providers shall be limited to the prevailing West Virginia Medicaid payment rate for these services with it being the state's obligation to pay any amount above the prevailing Medicaid rate if required.

§16-2L-6. Authorization.

(a) The secretary is directed to recognize provider sponsored networks in accordance with this article and

Medicaid departmental policies and is authorized to enter into contracts with provider sponsored networks to arrange for the provision of health care, services and supplies for Medicaid beneficiaries and thereby add the provider sponsored network program option to a county's Medicaid enrollees notwithstanding the prior availability or utilization of other options.

(b) The secretary is authorized to directly assign Medicaid beneficiaries who are patients of provider sponsored network participating primary care providers to a provider sponsored network in each county in which the secretary deems it desirable to utilize a provider sponsored network program. The secretary shall monthly update the assignment of Medicaid enrollees to the provider sponsored network participating primary care providers. Thereafter, Medicaid beneficiaries assigned to a provider sponsored network may change enrollment to a different provider sponsored network or to a managed care organization as the options may be available to them. Nothing in this article

requires that a Medicaid beneficiary who is a patient of a provider sponsored network participating provider must remain an enrollee in the provider sponsored network program. After initial assignment, the choice of health care provider and choice of Medicaid program provider is not limited by this article. Further, neither this article nor any regulation or directive of the Department of Health and Human Resources or its Bureau for Medical Service prohibits any Medicaid enrollee from choosing the option of receiving care through a provider sponsored network program except that, for administrative purposes, the secretary may designate the circumstances or frequency that the options may be exercised by Medicaid enrollees.

(c) The secretary may directly assign Medicaid beneficiaries to the provider sponsored network program and one of its primary care participating providers on a county by county basis: *Provided*, That the beneficiaries are currently receiving care from participating primary care providers of the provider sponsored network.

(d) The service, administrative and performance criteria to be met by provider sponsored networks shall be the same as required of other managed care organizations providing services to Medicaid enrollees in the state. The secretary shall, from time to time, designate the county or counties in which each provider sponsored network may provide care and arrange services for Medicaid enrollees.

(e) The secretary shall propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code to establish the requirements for the provider sponsored network program and to implement the policies and procedures required by this article.

§16-2L-7. Payment for provider sponsored network services.

(a) The secretary shall pay a provider sponsored network - risk the same payment rates as regularly paid to traditional managed care organizations as adjusted by program, region, benefit plan, age and sex. If there is no prevailing payment rate being paid to managed care organizations for that

Medicaid program, then the secretary shall offer an actuarially sound payment rate calculated to include applicable medical expenses, overhead and administrative costs which would be incurred or paid by the state if no provider sponsored network was available to provide and manage the care and the administration of the program. The secretary may offset the payments to a provider sponsored network - risk in amounts at prevailing West Virginia Medicaid rates as may be required to pay health care providers that are not participating providers in that provider sponsored network - risk for services approved by the provider sponsored network - risk which non–participating providers render and which were medically necessary and were covered under Medicaid.

(b) The secretary shall pay a provider sponsored network - shared savings the enhanced primary care case management fee, which compromises reimbursement for the enhanced primary care case management function as specified in the terms of the provider agreement and includes funding for the

provider sponsored network - shared savings to pay participating primary care providers for care management (e.g., care coordination, referrals) to Medicaid enrollees assigned to each participating primary care provider. The secretary shall make monthly enhanced primary care case management patients to the provider sponsored network - shared savings, and may make lump sum payments to the provider sponsored network, if eligible. The enhanced primary care case management fee shall be based on the enrollee's Medicaid eligibility category as specified in the provider agreement and paid on a per member per month basis. The provider sponsored network - shared savings will be eligible to receive up to sixty percent of savings if the actual aggregate costs of authorized services, including enhanced primary care case management fees advanced, are less than the aggregate per capita prepaid benchmark (for the entire provider sponsored network - shared savings enrollment). During a provider sponsored network - shared savings's first two years of operations, distribution of any

savings will be contingent upon the provider sponsored network-shared savings meeting the established performance measures and compliance under the provider agreement. After a provider sponsored network-shared savings's second year of operations, the provider sponsored network - shared savings will be required to convert to a provider sponsored network - risk.

§16-2L-8. Participation in provider sponsored networks.

(a) Any willing physician or licensed behavioral medicine provider is entitled to participate in a provider sponsored network provided that he, she or it is willing to participate in the health care delivery approach designed by the provider sponsored network in compliance with the requirements of the Department of Health and Human Resources or its Bureau for Medical Services. It is not a requirement that the physician provider agree to accept at-risk reimbursement such as capitation. However, in its participating provider contracts, the provider sponsored network may offer incentive reimbursements and provisions for varying

reimbursements according to the participating provider's willingness to accept varying degrees of business risk and according to actual health outcomes, patient satisfaction and costs of care for provider sponsored network patients. The provider sponsored network may require that its care management protocols be observed as a condition of provider participation. These protocols may include, but are not limited to, provisions for designations of certain services that may be provided only by designated providers, or classes of providers, requirements that providers be credentialed before they may provide certain services, and requirements that providers comply with utilization management programs and referral systems as established by the provider supported network.

(b) In order to preserve and enhance the provision of coordinated continuity-of-care, privately practicing participating providers will be given access to, and beneficial use of, provider sponsored network medical home resources and care management systems, provided that the access or

use is feasible and mutually desirable. A provider sponsored network may not require a participating physician provider to sell or transfer ownership of his, her or its assets or practice operations to the provider sponsored network or any of its constituent members as a condition of participation or permitted access or use.

(c) Licensed hospitals may participate in the provider sponsored network and contracts may include a provision for sharing of the business risk for providing care, services and supplies to the Medicaid beneficiaries. The provider sponsored network may require that its care management protocols be observed as a condition of hospital participation. These protocols may include, but are not limited to, provisions for designations of certain services that may be provided only by designated providers, or classes of providers, requirements that providers be credentialed before they may provide certain services, and requirements that providers comply with utilization management programs and referral systems as established by the provider supported network.

(d) A health care provider participating in a provider sponsored network retains the right to participate in, and contract with, other networks or other managed care organizations to provide services to Medicaid beneficiaries.

§16-2L-9.Anti-trust exemption.

Because agreement and coordination among health care providers, which may be potential competitors with each other, is required to establish and operate provider sponsored networks, an exemption from anti-trust laws for these activities will further the purposes of this article, the West Virginia Anti-Trust Act, article eighteen, chapter forty-seven of this code, shall not be interpreted to interfere with the development of provider sponsored networks under this article or to impose liability for any activities of a provider sponsored network or any arrangements between a provider sponsored network and its participating providers that are performed or entered into in furtherance of the purposes of, and activities contemplated by, this article. It is the intent of

the Legislature that the federal anti-trust statutes be interpreted in this manner as well.

§16-2L-10. Insurance.

(a) *Insurance risk.* -- The Department of Health and Human Resources Department and its Bureau for Medical Services shall retain the governmental insurance risks for care to be provided for enrollees in its Medicaid programs with respect to patients assigned to a provider sponsored network.

(b) *Business Risk.* -- Entities providing care as a provider sponsored network or a participating physician provider in a provider sponsored network may agree, as a part of his, her or its contract to provide services to Medicaid beneficiary patients of the provider sponsored network, to accept the business risk that more, or less, payments may be received as a result of the care provided to Medicaid patients as compared to payments which might otherwise be received through traditional insurance arrangements or the provision of services to be directly paid by the state.

(c) *Exclusion from insurance regulation.* -- None of the activities or arrangements entered into by the provider sponsored network with the Department of Health and Human Resources or its Bureau for Medical Services as provided herein are "insurance" or the activities of an "insurer" as defined by section two, article one, chapter thirty-three of this code, and the provider sponsored network programs and entities are not subject to regulation of the Insurance Commissioner, nor are they unauthorized insurers as defined by section three, article forty-four, chapter thirty-three of this code.

(d) *Insurance activities by provider sponsored networks.* -- If a provider sponsored network applies for and receives one or more insurance licenses or certificates of authority from the Insurance Commissioner, the activities of the provider sponsored network under those licenses or certificates of authority shall be subject to the regulation of the Insurance Commissioner under chapter thirty-three of this code.

§16-2L-11. Reports; shared savings; studies.

(a) The secretary shall report to the Legislature on June 30, 2013, and annually thereafter the number and locations of provider sponsored network programs implemented by the department in the previous fiscal year and the number of Medicaid enrollees affected. Every provider sponsored network, beginning with its third full year of operations as a provider sponsored network recognized by the secretary, shall share with the state an amount ("the shared amount") equal to twenty-five percent of its annual net income remaining after all provider sponsored network medical expenses, provider payments, loan repayments, and administrative and overhead costs, including taxes, have been deducted. In determining the shared amount, provider sponsored networks shall at all times maintain the capital and reserves required under this article, and may include up to, but no more than three years of prior losses as audited under generally accepted accounting principles.

(b) The secretary shall study and report to the Legislature the secretary's recommendations and conclusions regarding models of care other than provider sponsored networks and whether pilot programs are merited; and

(c) The secretary shall determine whether the current costs of using existing non-governmental service contract vendors for administrative or care management services for Medicaid programs can be reduced by contracting for a provider sponsored network to provide the same services and report the findings to the Legislature.

§16-2L-12. Provider sponsored network capital and surplus requirements.

A provider sponsored network arranging for health care services to beneficiaries of any and all Medicaid programs in West Virginia shall maintain minimum capital and surplus in an amount which is the greater of 2 million dollars, or ten per cent of total liabilities, or two per cent of projected annual Medicaid revenue received from the state.

§16-2L-13. Open application process.

The secretary is directed to recognize provider sponsored networks based on an open enrollment process, meaning that the secretary will timely offer the provider sponsored network designation to every provider sponsored network applicant that applies for and meets the standards for Medicaid provider sponsored networks pursuant to this article. The standards applied in determining whether to enter into a contract for services with a provider sponsored network may be the same as, less than, but no greater than the standards used in considering a contract with managed care organizations who provide services to the medicaid beneficiaries.

§16-2L-14. Reimbursement for services provided.

(a) Each provider sponsored network established under this article shall pay reasonable costs to the Department of Health and Human Resources associated with implementation of this article and oversight of the provider sponsored networks.

(b) When examining an entity to determine whether it meets, or continues to meet, the standards for a provider sponsored network pursuant to this article, the secretary may contract with the Office of Insurance Commissioner or retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the cost of which shall be born by the company that is the subject of the examination.