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COMMITTEE SUBSTITUTE

FOR

H. B. 4438

(By Delegates Perdue, Perry, Hamilton, Hartman, Poore, D. Campbell, M. Poling, Hatfield, Ellington, Hunt and Williams)

[Passed March 10, 2012; in effect ninety days from passage.]

AN ACT 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 and §16-2L-7; and to amend said code by adding thereto a new article, designated §33-25G-1, §33-25G-2, §33-25G-3, §33-25G-4 and §33-25G-5, all relating to provider sponsored networks; stating the purpose; making legislative findings; defining terms; authorizing the Secretary of the Department of Health and Human Resources to contract with provider sponsored networks to provide services to Medicaid beneficiaries; assigning certain medicaid beneficiaries to provider sponsored networks; guaranteeing Medicaid beneficiaries' freedom to choose a managed care plan; providing an exemption from anti-trust laws; requiring reports to the Legislature; providing for shared savings with the state; authorizing the Insurance Commissioner to license provider sponsored networks; subjecting provider sponsored networks generally to the laws governing HMOs; providing for

participation of health care providers in a provider sponsored network; permitting lower or different minimum capital and surplus amounts; and providing rule-making authority, including emergency rules.

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 and §16-2L-7; and that said code be amended by adding thereto a new article, designated §33-25G-1, §33-25G-2, §33-25G-3, §33-25G-4 and §33-25G-5, all to read as follows:

CHAPTER 16. PUBLIC HEALTH

ARTICLE 2L. PROVIDER SPONSORED NETWORKS.

§16-2L-1. Legislative purpose.

The Legislature finds that it inures to the benefit of the state and its Medicaid populations to foster the development of care systems and Medicaid options that allow for the functional integration and 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; that 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; that federally qualified health centers are deeply

engaged with integrating behavioral health providers and other community services in their care of Medicaid beneficiaries and that such centers lead in the development and implementation of recognized medical homes in West Virginia; and that better health outcomes can be achieved and inappropriate utilization avoided through the integration and coordination of physical health care with mental health care. Therefore, in order to develop innovative means of meeting the health care needs of the state's citizens and to address the impact on the state's budget arising from the growing cost of Medicaid, and in recognition of the important role that federally qualified health centers play in providing health care services to Medicaid beneficiaries, the Legislature authorizes the secretary to enter into contracts with provider sponsored networks.

§16-2L-2. Definitions.

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

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

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

(B) Without being limited to discrete episodes of care, medical records and care processes are used that track and manage health status over time and allow the medical professional to refer

care to, and receive reports from, other medical professionals and other care team members responsible for a patient's care.

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

(3) "Medicaid beneficiary" means any person participating, through either a state plan amendment or waiver demonstration, in any Medicaid program administered by the West Virginia Department of Health and Human Resources or its Bureau for Medical Services.

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

(5) "Participating provider" means a licensed health care provider who has entered into a contract with a provider sponsored network to provide services to Medicaid enrollees.

(6) "Participating primary care provider" is a primary care provider who is also a participating provider.

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

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

(9) "Provider sponsored network" means an entity licensed by the West Virginia insurance commissioner in accordance with article twenty-five-g, chapter thirty-three of this code.

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

§16-2L-3. Contracts with provider sponsored networks.

(a) The secretary is authorized to enter into contracts with any provider sponsored network licensed by the insurance commissioner in accordance with the provisions of article twenty-five-g, chapter thirty-three of this code, to arrange for the provision of health care, services and supplies for Medicaid beneficiaries. Such contract:

(1) Shall be subject to the same criteria and standards applied to other managed care organizations; and

(2) May provide that the provider sponsored network will share with the department up to 25% of any net profits realized during the period of the contract.

(b) 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 beneficiaries in the state.

(c) A licensed provider sponsored network shall be deemed an HMO for the purposes of federal regulations governing the Medicaid program to the extent permitted by such regulations.

§16-2L-4. Options for Medicaid beneficiaries; assignment of enrollees.

(a) Notwithstanding the prior availability or utilization of other options, every licensed provider sponsored network available

in a county shall be offered by the secretary as an enrollment option to that county's Medicaid beneficiaries. A provider sponsored network is deemed to be "available in a county" if the secretary has entered into a contract with it to provide services to Medicaid beneficiaries in that county.

(b) The secretary shall require that each eligible Medicaid beneficiary be given the option to choose any available managed care plan, including a provider sponsored network, to arrange for and provide his or her medical services under the Medicaid program, and nothing in this article shall be construed to remove or diminish the right of Medicaid beneficiaries to choose among such available options.

(c) The secretary shall seek approval from the Centers for Medicare and Medicaid Services to permit the assignment to an available provider sponsored network of any Medicaid beneficiary who does not exercise the option to choose a managed care plan or provider sponsored network offered to him or her. The secretary shall promulgate emergency rules and shall propose for legislative approval legislative rules as may be necessary to implement such assignment process.

(d) A Medicaid beneficiary assigned to a provider sponsored network or another managed care organization may change enrollment to any other available provider sponsored network or managed care organization as such options may be available, and nothing in this article requires that a Medicaid beneficiary who is a patient of a participating provider must remain an enrollee in the provider

sponsored network with which such participating provider has a contract.

§16-2L-5. Anti-trust exemption.

Because agreement and coordination among health care providers, who 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. Therefore, the West Virginia Anti-Trust Act, article eighteen, chapter forty-seven of this code, is inapplicable to the development of provider sponsored networks, activities necessary to operate provider sponsored networks or any arrangements or agreements between or among provider sponsored networks and participating providers that are performed or entered into consistent with and pursuant to the provisions of this article and the provisions of article twenty-five-g, chapter thirty-three of this code. It is the intent of the Legislature that the federal anti-trust statutes be interpreted in this manner as well.

16-2L-6. Rulemaking authority.

The secretary may promulgate emergency rules and shall propose for legislative approval legislative rules, in accordance with the provisions of article three, chapter twenty-nine-a of this code, as are necessary to provide for implementation and enforcement of the provisions of this article.

16-2L-7. Reports to the Legislature.

The secretary shall include in his or her annual report to the

Legislature the status of the provider sponsored network programs operating during the previous fiscal year.

CHAPTER 33. INSURANCE

ARTICLE 25G. PROVIDER SPONSORED NETWORKS.

§33-25G-1. Legislative findings.

The Legislature finds that, in light of the need to provide health care to a Medicaid population that is expected to rise dramatically in the near future, new models of managed care should be explored in order to enhance the state's ability to improve health outcomes and to manage the financial risk associated with the provision of such care. This article provides a licensing and regulatory scheme for provider sponsored networks, an alternative managed care model recognized in federal law, that recognizes the unique features of such entities.

§33-25G-2. Definitions.

(a) "Federally Qualified Health Center" means an entity as defined in 42 U.S.C. §1396d(l)(2)(B).

(b) "Medicaid beneficiary" means any person participating, through either a state plan amendment or waiver demonstration, in any Medicaid program administered by the West Virginia Department of Health and Human Resources or its Bureau for Medical Services.

(c) "Participating provider" means a licensed health care provider who has entered into a contract with a provider sponsored network to provide services to Medicaid enrollees.

(d) "Provider sponsored network" means an entity that satisfies the

definition of a "Medicaid managed care organization" set forth in 42 U.S.C. §1396b(m)(1)(A), is controlled by one or more Federally Qualified Health Centers, as set forth in 42 U.S.C. §1396b(m)(1)(C)(ii)(IV), and provides or otherwise makes available health care services solely to Medicaid beneficiaries or beneficiaries of medicaid or medicare pursuant to contract with the secretary executed in accordance with article two-l, chapter sixteen of this code.

(e) "Secretary" means the Secretary of the West Virginia Department of Health and Human Resources.

§33-25G-3. Licensing of provider sponsored networks.

(a) Except to the extent provided otherwise in this article, a provider sponsored network is subject to the provisions of article twenty-five-a of this chapter to the same extent as an HMO.

(b) Notwithstanding the provisions of section four, article twenty-five-a of this chapter, in determining whether a provider sponsored network has demonstrated in its application for a certificate of authority or at a later time that it is financially responsible and may reasonably be expected to meet its obligations to Medicaid beneficiaries, the commissioner may, in his or her sole discretion and after consultation with the secretary, impose lower or different solvency requirements, including lower surplus and capital. In deciding whether to permit lower or different solvency standards, the commissioner shall consider actuarial evaluations and other qualified technical standards and may also consider factors such as a lower risk of insolvency, any transfer of risk to

a third party, and the restriction of the provider sponsored network to the provision of Medicaid-related services; these same factors may also be considered in reviewing and acting upon a provider sponsored network's RBC report.

(c) A provider sponsored network may at any time seek to convert its certificate of authority granted pursuant to this article to a certificate of authority to operate as an HMO by filing an application in accordance with the provisions of article twenty-five-a of this chapter.

§33-25G-4. Provider participation.

(a) Any willing physician or licensed behavioral health provider is entitled to participate in a provider sponsored network provided that he or she is willing to participate in the health care delivery approach designed by the provider sponsored network and such other applicable requirements of the Department of Health and Human Resources.

(b) As a condition of provider participation, including participation by hospitals, a provider sponsored network may require that its care management protocols be observed, including 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 sponsored network. 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 participating providers as a condition of participation or of being permitted access or use of the provider sponsored network's medical home resources and care management systems.

(c) A participating provider shall have the right to participate in, and contract with, other networks or other managed care organizations to provide services to Medicaid beneficiaries.

33-25G-5. Rules.

The commissioner may promulgate emergency rules and shall propose for legislative approval legislative rules, in accordance with the provisions of article three, chapter twenty-nine-a of this code, as are necessary to provide for implementation and enforcement of the provisions of this article.