HB454

151908-4

By Representative McClendon

RFD: Ways and Means General Fund

First Read: 20-MAR-13

ENGROSSED

A BILL

TO BE ENTITLED

AN ACT

Relating to the Medicaid Agency; to provide for the delivery of medical services to Medicaid beneficiaries on a managed care basis through regional care organizations or alternate care providers.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. For the purposes of this act, the following words shall have the following meanings:

(1) ALTERNATE CARE PROVIDER. A contractor, other than a regional care organization, that agrees to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the state pursuant to a risk contract.

(2) CAPITATION PAYMENT. A payment the state Medicaid Agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services.

(3) CARE DELIVERY SYSTEM. The manner in which the benefits and services set forth in the state Medicaid plan are provided to Medicaid beneficiaries.

(4) 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 regional care organizations in the health care system.

(5) LONG-TERM CARE. Medicaid-funded nursing facility services or services in intermediate care facilities for the developmentally disabled, or home- and community-based support services provided to individuals who might otherwise require such services, or such other long-term care services as the Medicaid Agency may determine by rule.

(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) MEDICAID BENEFICIARY. Anyone determined by the Medicaid Agency to be eligible for Medicaid.

(8) QUALITY-ASSURANCE PROVISIONS. Specifications for assessing and improving the quality of care provided by a regional care organization or an alternative care plan.

(9) 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 and that meets the requirements set forth in this act.

(10) RISK CONTRACT. A contract under which the contractor 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.

Section 2. (a) A regional care organization shall serve only Medicaid beneficiaries in providing medical care and services.

(b) Notwithstanding any other provision of law, a regional care organization shall not be deemed an insurance company under state law.

(c)(1) A regional care organization and an organization with probationary regional care organization certification shall have a governing board of directors composed of the following members:

a. Twelve members shall be persons representing risk-bearing participants in the regional care organization <u>or organization with probationary certification</u>. A participant bears risk by contributing cash, capital, or other assets to the regional care organization. A participant also bears risk by contracting with the regional care organization to treat Medicaid beneficiaries at a capitated rate per beneficiary or to treat Medicaid beneficiaries even if the regional care organization does not reimburse the participant.

b. Eight members shall be persons who do not represent a risk-bearing participant in the regional care organization. Of these eight members, five members shall be medical professionals who provide care to Medicaid

beneficiaries in the region. ~~Two~~ Three of these members shall be primary care physicians, ~~one a dentist,~~ one an optometrist, and one a pharmacist. ~~The~~ One primary care physician shall be from a Federally Qualified Health Center appointed jointly by the Alabama Primary Health Care Association and the Alabama Chapter of the National Medical Association and the other two primary care physicians shall be appointed by a caucus of county boards of health in the region. ~~The dentist shall be appointed by the Alabama Dental Association, or its successor organization.~~ The optometrist shall be appointed by the Alabama Optometric Association, or its successor organization. The pharmacist shall be appointed by the Alabama Pharmacy Association, or its successor organization. All five medical professionals shall work in the region served by the regional care organization. None of these members shall be a risk-bearing participant in the regional care organization or be an employee of a risk-bearing participant, but these members may contract with the regional care organization on a fee-for-service basis.

c. Three members shall be community representatives as follows: 1. The chair of the citizens' advisory committee established pursuant to subsection (d). 2. Another citizens' advisory committee member, elected by the committee, who is a representative of an organization that is part of the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations. 3. A business executive, nominated by a chamber of commerce in the region, who works in

the region. These members may not be risk-bearing participants in the regional care organization or employees of a risk-bearing participant.

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

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

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

(5) The governing board may not take any action unless at least one physician appointed by a caucus of county boards of health in the region, who does not represent a risk-bearing participant and who does not hold one of the three seats held by community representatives, votes on the prevailing side.

(6) The membership of the governing board of directors shall be inclusive and reflect the racial, gender, geographic, urban/rural and economic diversity of the region.

(d) A citizen's advisory committee shall advise the organization on ways the organization may be more efficient in providing quality care to Medicaid beneficiaries. In addition, an advisory committee shall carry out other functions and duties assigned to it by a regional care organization and approved by the Medicaid Agency. Each regional care organization shall have a citizens' advisory committee, as shall an organization seeking to become a regional care organization. The committee shall meet all of the following criteria:

(1) Be selected in a method established by the organization seeking to become a regional care organization, or established by the regional care organization, and approved by the Medicaid Agency.

(2) At least 20 percent of its members shall be Medicaid beneficiaries or, if the organization has been certified as a regional care organization, at least 20 percent of its members shall be Medicaid beneficiaries enrolled in the regional care organization.

(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.

(4) Include only persons who live in the Medicaid region the organization plans to serve; or if the organization has become a regional care organization, include only persons who live in the Medicaid region served by the regional care organization. The membership of the committee shall be inclusive and reflect the racial, gender, geographic, urban/rural and economic diversity of the region.

(5) Elect a chair.

(6) Meet at least every three months.

(e)(1) Each regional care organization shall meet minimum solvency and financial requirements as provided in this subsection. The Medicaid Agency shall require a regional care organization, as a condition of certification or continued certification, to maintain minimum financial reserves at the following levels:

a. Restricted reserves of two hundred fifty thousand dollars ($250,000) or an amount equal to 25 percent of the regional care organization's total actual or projected average monthly expenditures, whichever is greater.

b. Capital or surplus, or any combination thereof, of two million five hundred thousand dollars ($2,500,000).

(2) Instead of maintaining the financial reserves required in subdivision (1), a regional care organization that has entered into a risk contract with the Medicaid Agency may submit to the agency a written guaranty in the form of a bond issued by an insurer, in an amount equal to the financial reserves that would otherwise be required of the regional care

organization under subdivision (1), to guarantee the performance of the provisions of the risk contract. The bond shall be issued by an insurer authorized in this state and approved by the Medicaid Commissioner. No assets of the regional care organization shall be pledged or encumbered for the payment of the performance bond.

(f) A regional care organization shall provide such financial reports and information as required by the Medicaid Agency.

(g) A regional care organization shall report all data as required by the Medicaid Agency, consistent with the federal Health Insurance Portability and Accountability Act (HIPAA).

Section 3. The Medicaid Agency shall establish by rule geographic Medicaid regions in which a regional care organization or alternate care provider may operate, which together shall cover the entire state. Each Medicaid region, according to an actuary working for Medicaid, shall be capable of supporting at least two regional care organizations or alternate care providers.

Section 4. (a) Subject to approval of the federal Centers for Medicare and Medicaid Services, the Medicaid Agency shall enter into a contract in each Medicaid region for at least one fully certified regional care organization to provide, pursuant to a risk contract under which the Medicaid Agency makes a capitated payment, medical care to Medicaid beneficiaries. However, 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. The Medicaid Agency may contract with more than one regional care organization in a Medicaid region. Pursuant to the contract, the Medicaid Agency shall set capitation payments for the regional care organization.

(b) The Medicaid Agency shall enroll beneficiaries into regional care organizations. If more than one regional care organization operates in a Medicaid region, a Medicaid beneficiary may choose the organization to provide his or her care. If a Medicaid beneficiary does not make a choice, the Medicaid Agency shall assign the person to a care organization. Medicaid may limit the circumstances under which a Medicaid beneficiary may change care organizations.

(c) A regional care organization shall provide Medicaid services to Medicaid enrollees directly or by contract with other providers. The regional care organization shall establish an adequate medical service delivery network as determined by the Medicaid Agency. An alternate care provider contracting with Medicaid shall also establish such a network.

(d) The Medicaid Agency shall establish by rule procedures for safeguarding against wrongful denial of claims and addressing grievances of enrollees in a regional care organization or an alternate care provider. The procedures

shall provide for a timely and meaningful right of appeal, by Medicaid enrollees or their providers, of approvals or denials of care, billing and payment issues, bundling matters, and the provision of health care services. The rules shall include procedures for a fair hearing on all claims or complaints brought by Medicaid enrollees or other providers that shall include the following:

(1) An immediate appeal to the medical director of the regional care organization, who shall be a primary care physician. The rules of evidence shall not apply. The medical director shall consider the materials submitted on the issue and any oral arguments and render a decision. The medical director's decision shall be binding on the regional care organization.

(2) If a patient or provider is dissatisfied with the decision of the medical director, the patient or physician may file a notice of appeal to be heard by a peer review committee. The peer review committee shall be composed of at least three physicians of the same specialty in the region in which the services or matter is at issue. If three physicians cannot be found, then the physicians may be selected outside of the region. The Medicaid Agency shall develop rules regarding the appeal to the peer review committee. The peer review committee's decision shall be binding on the regional care organization.

(3) If a patient or the provider is dissatisfied with the decision of the peer review committee, 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 regional care organization. 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.

(e) The Medicaid Agency shall by rule establish procedures for addressing grievances of regional care organizations. The grievance procedure shall include an opportunity for a fair hearing before an impartial hearing officer in accordance with the Alabama 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 Alabama 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 agency may adopt rules for implementing this subsection in accordance with the Alabama Administrative Procedure Act.

(f) In addition to the foregoing, the Medicaid Agency shall do all of the following:

(1) Establish by rule the criteria for probationary and full certification of regional care organizations.

(2) Establish the quality standards and minimum service delivery network requirements for regional care organizations or alternate care providers to provide care to Medicaid beneficiaries.

(3) Establish by rule and implement quality assurance provisions for each regional care organization.

(4) Adopt and implement, at its discretion, requirements for a regional care organization concerning health information technology, data analytics, quality of care, and care-quality improvement.

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

(6) Take such other action with respect to regional care organizations or alternate care providers 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 the regional care organizations or alternate care providers qualify for federal matching funds.

Section 5. (a) The Medicaid Agency shall create a quality assurance committee appointed by the Medicaid Commissioner. The members of the committee shall serve two-year terms. At least 60 percent of the members shall be physicians who provide care to Medicaid beneficiaries served by a regional care organization. In making appointments to the committee, the Medicaid Commissioner shall seek input from the appropriate professional associations.

(b) The committee shall identify objective outcome and quality measures, including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care, and all other health services provided by coordinated care organizations. Quality measures adopted by the committee shall be consistent with existing state and national quality measures. The Medicaid Commissioner shall incorporate these measures into regional care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements.

(c) The committee shall adopt outcome and quality measures annually and adjust the measures to reflect the following:

(1) The amount of the global budget for a regional care organization.

(2) Changes in membership of the organization.

(3) The organization's costs for implementing outcome and quality measures.

(4) The community health assessment and the costs of the community health assessment conducted by the organization.

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

(e) 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.

(f) 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, by regional care organizations, all of the following:

(1) Quality measures.

(2) Costs.

(3) Outcomes.

(4) Other information, as specified by the contract between the regional care organization and the Medicaid Agency, that is necessary for the Medicaid Agency to evaluate the value of health services delivered by a regional care organization.

Section 6. An initial contract between the Medicaid Agency and a regional care organization shall be for three years, with the option for Medicaid to renew the contract for not more than two additional one-year periods. The Medicaid Agency shall obtain an independent evaluation of the cost

savings, patient outcomes, and quality of care provided by each regional care organization, and obtain the results of each regional care organization's evaluation in time to use the findings to decide whether to enter into another multi-year contract with the regional care organization or change the Medicaid region's care-delivery system.

Section 7. The Medicaid Agency may contract with an alternate care provider in a Medicaid region only under the terms of this section:

(a) If a regional care organization failed to provide adequate service pursuant to its contract, or had its certification terminated, or if the Medicaid Agency could not award a contract to a regional care organization under the terms of Section 4, or if no organization had been awarded a regional care organization certificate by October 1, 2016, then the Medicaid Agency shall first offer a contract, to resume interrupted service or to assume service in the region, under the conditions of Section 4 to any other regional care organization that Medicaid judged would meet its quality criteria.

(b) If by October 1, 2014, no organization had a probationary regional care organization certification in a region. However, the Medicaid Agency could extend the deadline until January 1, 2015, if it judged an organization was making reasonable progress toward getting probationary certification. If Medicaid judged that no organization in the region likely would achieve probationary certification by January 1, 2015,

then the Medicaid Agency shall let any organization with probationary or full regional care organization certification apply to develop a regional care organization in the region. If at least one organization made such an application, the agency no sooner than October 1, 2015, would decide whether any organization could reasonably be expected to become a fully certified regional care organization in the region and its initial region.

(c) If an organization lost its probationary certification before October 1, 2016, Medicaid shall offer any other organization with probationary or full regional care organization certification, which it judged could successfully provide service in the region and its initial region, the opportunity to serve Medicaid beneficiaries in both regions.

(d) Medicaid may contract with an ~~alternative~~ alternate care provider only if no regional care organization accepted a contract under the terms of (a), or no organization was granted the opportunity to develop a regional care organization in the affected region under the terms of (b), or no organization was granted the opportunity to serve Medicaid beneficiaries under the terms of (c).

(e) The Medicaid Agency may contract with an alternate care provider under the terms of subsection (d) only if, in the judgment of the Medicaid Agency, care of Medicaid enrollees would be better, more efficient, and less costly than under the then existing care delivery system. Medicaid

may contract with more than one alternate care provider in a Medicaid region.

~~(f)(1) If the Medicaid Agency were to contract with an alternate care provider under the terms of this section, that provider would have to pay reimbursements for hospital inpatient or outpatient care at rates at least equal to those most recently paid directly by the state Medicaid Agency either through base payments or access payments.~~

~~(2) If more than a year had elapsed since the Medicaid Agency directly paid reimbursements to hospitals, the minimum reimbursement rates paid by the alternate care provider would have to be changed to reflect any percentage increase in the national medical consumer price index minus 100 basis points. The indexing requirement of this subdivision shall cease to be effective on October 1, 2016.~~

Section 8. (a) The Medicaid Agency shall establish by rule the procedure for the termination of a regional care organization certification or probationary regional care organization certification for non-performance of contractual duty or for failure to meet or maintain benchmarks, standards, or requirements provided by this act or established by the Medicaid Agency as required by this act.

(b) Termination of a regional care organization certification or probationary certification shall follow the standard administrative process, with the right to a hearing before a hearing officer appointed by the Medicaid Agency.

Section 9. A regional care organization shall contract with any willing hospital, doctor, or other provider to provide services in a Medicaid region if the provider is willing to accept the payments and terms offered comparable providers. 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 10. (a) The following is the timeline for implementation of this act:

(1) Not later than October 1, 2013, the Medicaid Agency shall establish Medicaid regions.

(2) Not later than ~~April~~ October 1, 2014, an organization seeking to become a regional care organization shall have established a governing board and structure as approved by the Medicaid Agency. An organization may receive probationary certification as a regional care organization upon submission of an application for, and demonstration of, a governing board acceptable to the Medicaid Agency. Probationary certification shall expire no later than October 1, 2016.

(3) Not later than April 1, 2015, an organization with probationary regional care organization certification shall have demonstrated to Medicaid's approval the ability to establish an adequate medical service delivery network.

(4) Not later than October 1, 2015, an organization with probationary regional care organization certification

shall have demonstrated to Medicaid's approval that it has met the solvency and financial requirements for a regional care organization as outlined in this act.

(5) Not later than October 1, 2016, an organization with probationary regional care organization certification shall demonstrate to Medicaid's approval that it is capable of providing services pursuant to a risk contract.

(b) The timeline and benchmarks in subsection (a) shall not preclude an organization from meeting the timelines and benchmarks at an earlier date.

(c) Failure to meet and maintain any one of the benchmarks in subdivisions (2) to (5), inclusive, shall constitute grounds for termination of a probationary regional care organization certification or full regional care organization certification. The Medicaid Agency shall award full regional care organization certification to an organization with probationary regional care organization certification if the organization timely meets each of those benchmarks. Failure by an organization to timely meet one or more of those benchmarks shall not prevent the Medicaid Agency, at its sole discretion, from granting full regional care organization certification to the organization as long as it has met all of those benchmarks by October 1, 2016.

Section 11. (a) The Medicaid Agency<u>, with input from long-term care providers,</u> shall conduct an evaluation of the existing long-term care system for Medicaid beneficiaries and,

~~by~~ 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 12. (a) The Medicaid Agency, with input from dental care providers, shall conduct an evaluation of the existing dental care program for Medicaid beneficiaries and, on October 1, 2015, shall report the findings of the evaluation to the Legislature and Governor.

(b) Notwithstanding the above, the current Medicaid dental 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 13. The Medicaid Agency may contract for case-management services with an organization that has been granted by the Medicaid Agency a probationary regional care organization certification. If the agency has contracted with

such an organization, and that organization on or before October 1, 2016, has failed to gain full regional care organization certification or has had its probationary certification terminated, then that organization shall refund half the payments, made by the Medicaid Agency to the organization for case-management services, paid over the previous 12 months.

Section 14. (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, and contractors that are carrying out the state's policy and regulatory program of health care delivery.

(b) The Medicaid Agency shall adopt 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, 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 the regional care organization 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 regional care organizations.

(d) All agreements and contracts shall be approved by the Medicaid Commissioner.

(e) Should collaborators or a regional care organization be 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 the commissioner's designee 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 regional care organizations to facilitate the development and establishment of the regional care organizations and health care payment reforms. Any participation by such entities and individuals shall be on a voluntary basis.

(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 regional care organizations are participating in good faith negotiations, cooperation, bargaining, or contracting in ways that support the intent of establishment of the regional care organization or other health care payment reforms, those

state-authorized collaborators and regional care organizations 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 subsection or act shall apply to 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 agreements approved under this act to ensure that a

collaborator's or regional care organization's performance under the agreement remains in compliance with the conditions of approval. Upon request and not less than annually, a collaborator or regional care organization 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 15. The Medicaid Agency may adopt rules necessary to implement this act.

Section 16. All laws or parts of laws which conflict with this act are repealed.

Section 17. This act shall become effective immediately following its passage and approval by the Governor, or its otherwise becoming law.

House of Representatives

Read for the first time and referred to the House of Representatives committee on Ways and Means
General Fund..... ..... 20-MAR-13

Read for the second time and placed on the calendar with 1 substitute and 2 amendments..... ..... 18-APR-13

Read for the third time and passed as amended..... ..... 23-APR-13

Yeas 78, Nays 20, Abstains 1

Jeff Woodard
Clerk