BURR ARTICLE

Alabama Medicaid: The Move to a Managed Care Program (Part I)

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On May 17, 2013, Governor Bentley signed into law Act 2013-261, *Ala. Code* §§ 22-6-150 *et seq*., which changes the Alabama Medicaid system from a fee-for-service to a managed care program (the "Act"). This historic legislation will result in nearly 1 million Alabama Medicaid beneficiaries receiving care from new entities called regional care organizations or "RCOs". Each RCO will receive a capitated per-member per-month fee from the Medicaid Agency in return for providing health care services to beneficiaries assigned to the RCO. RCOs must be established no later than October 1, 2014, with the provision of care starting October 1, 2016. According to the Medicaid Agency, the new managed care program is estimated to save Alabama and the federal government between $748 million and $1.079 billion over five years.

Following is a summary of the key elements of the Act, along with a discussion of regulations and other guidance issued by the Alabama Medicaid Agency (the "Agency"). To date, only a few regulations have been issued, and therefore much of what is known about RCOs and the Medicaid managed care program is taken from the Act itself. Part I of this paper will discuss organizational and operational requirements of RCOs, while Part II published next month will discuss the antitrust immunity provided to third-party payers, health care providers and other individuals and corporations (called "collaborators" under the Act) to collectively cooperate, negotiate and agree on price and health care delivery.

FORMATION OF RCOS

According to a report by the Alabama Medicaid Advisory Commission issued in January 2013, for the calendar year 2011 approximately 22 percent of Alabama citizens qualified for Medicaid services at least a portion of the year. For that same time period, Medicaid covered 53 percent of births, 47 percent of children, and almost two-thirds of nursing home residents. In fiscal year 2012, total Medicaid expenditures were $5.63 billion, with the State contributing $1.835 billion, and the remaining funds coming from the federal government. Medicaid enrollment growth, medical inflation, benefit changes, federal match rate changes and utilization are all cited as factors causing an increase in Medicaid spending over the last five years.

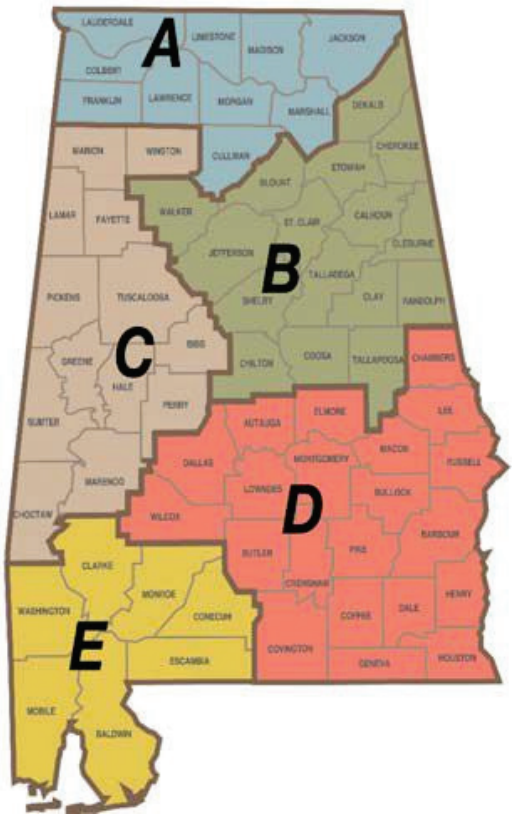
To combat the increasing State costs associated with Medicaid, the Act creates a new managed care program. The program will be administered by RCOs, which are corporate entities to be formed by health care providers, including physicians and hospitals. Each RCO will contract with the Agency "to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the state", excluding long-term and dental care, which will continue for the time-being under the current Medicaid payment system. A RCO will provide services in an assigned region of the State through its owners and contracts with other health care providers.

The Agency will enroll Medicaid beneficiaries in each RCO. If, however, more than one RCO operates in a region, the beneficiary can choose which RCO to join. If the beneficiary does not make a choice, he or she will be assigned to a RCO by the Agency. Limitations will be placed on beneficiaries moving between RCOs in the same region.

RCO REGIONS

Alabama Administrative Code § 560-X-37-.07 divides the State into five RCO regions. The regions were chosen to maintain existing referral patterns and to keep health systems together when possible. Each region has been determined capable of supporting at least two RCOs. The five RCO regions are as follows:

- *Region A*: Colbert, Cullman, Franklin, Jackson, Lauderdale, Lawrence, Limestone, Madison, Marshall and Morgan counties.
- *Region B*: Blount, Calhoun, Cherokee, Chilton, Cleburne, Clay, Coosa, Dekalb, Etowah, Jefferson, Randolph, Shelby, St. Clair, Talladega, Tallapoosa and Walker counties.
- *Region C*: Bibb, Choctaw, Fayette, Greene, Hale, Lamar, Marengo, Marion, Perry, Pickens, Sumter, Tuscaloosa and Winston counties.
- *Region D*: Autauga, Barbour, Bullock, Butler, Chambers, Crenshaw, Coffee, Covington, Dale, Dallas, Elmore, Geneva, Henry, Houston, Lee, Lowndes, Macon, Montgomery, Pike, Russell and Wilcox counties.
- *Region E*: Baldwin, Clarke, Conecuh, Escambia, Mobile, Monroe and Washington counties.



RCO CAPITATION CONTRACTS WITH MEDICAID

Subject to approval by the Centers for Medicare and Medicaid Services, the Agency will enter into a capitated risk contract with each RCO to provide medical care to Medicaid beneficiaries assigned to the RCO. Capitated rates can vary between RCOs, even those operating in the same region. A risk contract will only be executed if, in the judgment of the Agency, "care of Medicaid beneficiaries would be better, more efficient, and less costly" than the existing fee-for-service payment system. Even though a RCO assumes risk for paying for health care services, under the Act a RCO will not be considered an insurance company.

THE RCO GOVERNING BODY

A RCO is governed by a Board of Directors comprised of twenty-three (23) members. The Board membership, along with its bylaws, rules and procedures are subject to approval by the Agency. Special interest groups had significant influence over the Act, resulting in a rather convoluted Board comprised of the following members:

- Twelve members representing "risk-bearing" participants in the RCO. A participant bears risk by contributing cash, capital, or other assets to the RCO. A participant also bears risk by contracting with the RCO to treat Medicaid beneficiaries at a capitated rate.

- Eight members who do not represent "risk-bearing" participants in the RCO and are not employees of risk-bearing participants. Of these eight members, five must be medical professionals who work in the region served by the RCO, provide care to Medicaid beneficiaries served by the RCO and represent the following:
    - A total of three primary care physicians, with one 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 physicians appointed by a caucus of county boards of health in the RCO region.
    - One optometrist appointed by the Alabama Optometric Association, or a successor organization.
    - One pharmacist appointed by the Alabama Pharmacy Association, or a successor organization.

- Three members shall be community representatives who are not "risk-bearing" participants and who are not employees of risk-bearing participants. These members are comprised of the following:
    - The chair of the RCO Citizens' Advisory Committee, discussed below. This committee advises the RCO on providing quality care to Medicaid beneficiaries.
    - Another member of the Citizens' Advisory 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.
    - A business executive, nominated by the chamber of commerce in the region served by the RCO and who works in that region.

In addition, a majority of the Board members may not represent a single type of provider, such as hospitals or physician practices.

RCO PROVIDER NETWORKS AND PROVISION OF CARE

Each RCO is required to establish a network of health care providers in order to deliver care to its enrollees. The network can include physicians, hospitals, pharmacies, podiatrists, chiropractors, psychologists, dentists, therapists, social-workers, rural health clinics and other health care providers. Instead of contracting directly with a provider, a RCO can also contract with a managed care organization to provide health care services. At a minimum, a provider must comply with applicable licensing requirements, maintain a Medicaid provider number and must not be excluded from the Medicare or Medicaid programs. A RCO is required by the Act to contract with any willing hospital, physician or other provider to offer services to beneficiaries in the RCO region if the provider is willing to accept the same payment and contract terms offered by the RCO to other comparable providers. Payments by the RCO to a provider may be on a capitated or fee-for-service basis, and the RCO can implement value, performance and other payment methodologies.

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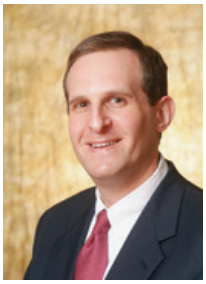

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