GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 372
PROPOSED COMMITTEE SUBSTITUTE H372-PCS30392-TR-1

Short Title: 2015 Medicaid Modernization. (Public)

Sponsors:

Referred to:

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE AND STABILIZE NORTH CAROLINA'S MEDICAID PROGRAM THROUGH PROVIDER-LED CAPITATED HEALTH PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid program to a program that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid program shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.
(2) Ensure balanced quality, patient satisfaction, and financial measures.
(3) Ensure efficient and cost-effective administrative systems and structures.
(4) Ensure a sustainable delivery system.
(5) Improve health outcomes for the State's Medicaid population.

SECTION 2. Definitions. – As used in this act, the following terms have the following definitions:

(1) Capitation payment. – As defined in 42 C.F.R. 438.2.
(2) CMS. – The Centers for Medicare and Medicaid Services.
(3) Department. – The North Carolina Department of Health and Human Services.
(4) Provider. – As defined in G.S. 108C-2(10).
(5) Provider-led entity. – Any of the following:
    a. A provider.
    b. An entity with the primary purpose of owning or operating one or more providers.
    c. A business entity in which providers hold a controlling ownership interest.
(6) Recipient. – An individual who has been determined to be eligible for Medicaid or NC Health Choice.
(7) Secretary. – The Secretary of the Department.

SECTION 3. Structure of Delivery System. – The structure of the transformed Medicaid program required in Section 1 of this act shall be as follows:

(1) Provider-led entities shall implement full-risk capitated health plans to manage and coordinate the care for enough program aid categories to cover at least ninety percent (90%) of Medicaid recipients to be phased in over five years from the date this act becomes law. Program aid category coverage shall not include dual eligibles for whom Medicaid pays only Medicare

premiums. In aggregate, provider-led entities shall cover Medicaid recipients in all 100 counties.

(2) Provider-led entities ensure appropriate access to care for Medicaid recipients in all 100 counties while building upon the existing enhanced primary care medical home model.

(3) Provider-led entity contracts result in controlling the State's cost growth at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

(4) The Department implements a process for recipient assignment to provider-led entities. Assignment shall be based on the recipient's selection of a provider-led entity, or if the recipient fails to choose a provider-led entity during initial enrollment, the Department shall develop a process for auto-assignment to a provider-led entity. The Department may limit the circumstances under which a Medicaid recipient may change provider-led entity, including creating an open enrollment period.

(5) When fully implemented, the State retains only the risk of enrollment numbers and enrollment mix of the populations for which capitated payments are received.

(6) Capitated payments will be actuarially sound and risk-adjusted, based on the mix of enrollees by program aid category and other appropriate factors.

(7) The Department ensures administrative costs are minimized and establishes appropriate medical loss ratio for contractors accepting full-risk capitation, which allocates at least ninety percent (90%) of the capitated payments to cover patient care.

(8) The Department ensures contracts required under this act contain effective program integrity features to protect against provider fraud, waste, and abuse at all levels of the system.

(9) Provider-led entities will be responsible for all administrative functions for recipients enrolled in their plan, including, but not limited to, all claims processing, care management, case management, appeals, and all other necessary administrative services.

(10) A majority of each provider-led entity's governing board shall be comprised of physicians who treat Medicaid patients including those who provide clinical services to Medicaid patients.

SECTION 4. Time Line. – The following milestones for Medicaid transformation shall occur in the following order and relative time frame.

(1) Within 12 months of this act becoming law, the Department shall develop, with meaningful stakeholder engagement, and submit to CMS a request for an 1115 Medicaid demonstration waiver to implement the components of this act.

(2) Within 24 months of this act becoming law and with waiver approvals from CMS, the Department will issue an RFP for provider-led entities to bid on contracts required under this act.

(3) Within five years of the date this act becomes law, ninety percent (90%) of Medicaid recipients shall be enrolled in full-risk, capitated health plans for all services other than the services contracted for through the local management entities/managed care organizations (LME/MCOs), dental services, and pharmaceutical products. However, prior to reaching the coverage required under this subdivision, the Department may accept a

full-risk, capitated health plan as a pilot that begins within three years of enactment of this act.

(4) Within six years of the date this act becomes law, each provider-led entity under contract with the Department must meet the risk, cost, performance, and quality goals required by this act and as contained in the contract with the Department.

SECTION 5. Submission of Waiver. – The Department shall submit to CMS the 1115 waiver and any other waivers and State Plan amendments necessary to accomplish the requirements of this act within the required time frames.

SECTION 6. Components of RFP/Terms and Conditions of Contracts. – The following are mandatory components the Department must include in the RFP and in all contracts required under Section 3 of this act.

(1) No bid may be considered if it does not, at a minimum, provide for all of the following:
   a. Cover a defined population of at least 30,000 recipients.
   b. Ensure appropriate access to care for recipients.

(2) Individually, bidders must:
   a. Agree to receive risk-adjusted capitation rates for all health benefits and administrative services, including physical, long-term services and supports, and other medical services generally considered physical care.
   b. Agree to transition to full-risk capitation for all services and related administrative costs for enrolled populations within the three to five years following the enactment of this act.
   c. Agree to defined measures for risk-adjusted health outcomes, quality of care, patient satisfaction, and costs.
   d. Meet financial solvency requirements developed by the Department of Insurance that are equivalent to the solvency requirements for health maintenance organizations in G.S. 58-67-110.
   e. Assume responsibility for complying with appeal rights and program integrity functions.
   f. Meet all data systems standards.

(3) Collectively, bidders are responsible for:
   a. Coverage for all 100 counties.
   b. Managing ninety percent (90%) of the State's Medicaid population within five years of enactment. All dual eligibles shall be excluded.
   c. A reduction of at least two percentage (2%) points below the national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

(4) All contracts must:
   a. Include clear performance goals based on the defined measures that are monitored and measured at specified and appropriate intervals.
   b. Provide penalties for failure to meet the performance goals.
   c. Provide financial rewards for achieving performance goals.
   d. Be for a term of five years with options to renew or extend based upon successful performance, as determined by the Department and contained in the contract.
   e. Adhere to the quality standards that are developed by the Quality Assurance Advisory Committee and are consistent with State and national quality measures.

SECTION 7. DHHS to Lead. – The General Assembly delegates full authority to the Department of Health and Human Services to take all actions necessary to implement the Medicaid transformation described in this act. The Department shall administer and manage the program within the budget enacted by the General Assembly provided that the total expenditures, net of agency receipts, for the Medicaid program do not exceed the enacted budget. The Department shall employ or contract with individuals who have the appropriate experience and competencies to manage the State's Medicaid program in a predominantly contract environment. To ensure a successful program, the Department shall do all of the following:

(1) Establish procedures and criteria for certifying that contracts entered into under Section 6 of this act establish an adequate medical services delivery network, including determining criteria to ensure Medicaid recipients have access to all medically necessary services.

(2) Establish quality standards and minimum services delivery network requirements for contracts entered into under Section 6 of this act.

(3) Ensure recipients have appropriate access to primary care and specialty care services and shall develop a rate floor for this purpose.

(4) Establish and implement quality assurance measures for the contracts entered into under Section 6 of this act.

(5) Adopt and implement requirements for the contracts entered into under Section 6 of this act concerning Health Information Technology, robust data analytics, quality of care, and care-quality improvement.

(6) Ensure that providers are required to manage care under appropriate evidence-based standards of care to more efficiently manage utilization and clinical resources.

(7) Encourage providers to utilize appropriate technologies, such as telemedicine, to provide expeditious care and ensure access to services.

(8) Establish procedures for termination of a contract entered into under Section 6 of this act for nonperformance of contractual duty or failure to meet or maintain benchmarks, standards, or requirements provided by this act or established by the Department.

SECTION 8. Quality Assurance Advisory Committee. – The Secretary shall convene an advisory committee consisting of experts in the areas of Medicaid, actuarial science, health economics, health benefits, and administration of health law and policy. At least one shall be a member of the North Carolina State Health Coordinating Council.

The Committee shall advise the Department on the development and submission of requests for all federal waivers that are necessary to implement this act and to support the development and approval of the performance goals that will serve as the basis of the pay-for-performance system. The committee shall terminate five years from the date of enactment of this act.

SECTION 9. Audits of Plans. – The Department shall contract for periodic financial audits of each successful bidder based on the terms and conditions of the awarded contract.

SECTION 10.(a) Maintain Funding Mechanisms. – The Department shall work with CMS to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the greatest extent possible. If such Medicaid-specific funding cannot be maintained, then the Department shall advise the Joint Legislative Oversight Committee created in Section 11 of this act of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation.

SECTION 10.(b) Maintain Existing 1915 (b)/(c) Waiver. – The Department shall continue implementation of the existing 1915(b)/(c) waiver.

SECTION 11.(a) Legislative Oversight of Medicaid. – Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on Medicaid.

"**§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Medicaid.**

(a) The Joint Legislative Oversight Committee on Medicaid is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-209.1. Purpose and powers of Committee.**

(a) The Joint Legislative Oversight Committee on Medicaid shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs and to the Department of Health and Human Services.

(b) The Committee shall make periodic reports to the General Assembly on matters for which it may report to a regular session of the General Assembly.

"**§ 120-209.2. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medicaid. The Committee shall meet upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge.

"**§ 120-209.3. Additional powers.**

The Joint Legislative Oversight Committee on Medicaid, while in discharge of official duties, shall have access to any paper or document, and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee.

"**§ 120-209.4. Reports to Committee.**

Whenever the Department is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters affecting the Medicaid or NC Health Choice programs, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Medicaid."

SECTION 11.(b) G.S. 120-208.1(a)(2)b. is repealed.

SECTION 12. Appropriation. – To accomplish the Medicaid transformation required by this act, there is appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of two million five hundred thousand dollars ($2,500,000) in nonrecurring funds for the 2015-2016 and the 2016-2017 fiscal years. These funds shall provide a State match for an estimated two million five hundred thousand dollars ($2,500,000) in federal funds beginning in the 2015-2016 fiscal year, and those federal funds are hereby appropriated to the Division of Medical Assistance to pay for Medicaid transformation.

SECTION 13. Section 12 of this act becomes effective upon appropriation by the General Assembly of funds for the implementation of this act. The remainder of this act is effective when it becomes law.