

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2015

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HOUSE BILL 372  
Committee Substitute Favorable 6/11/15  
PROPOSED COMMITTEE SUBSTITUTE H372-PCS40474-MM-21

Short Title: 2015 Medicaid Modernization.

(Public)

Sponsors:

Referred to:

March 30, 2015

1 A BILL TO BE ENTITLED  
2 AN ACT TO MODERNIZE AND STABILIZE NORTH CAROLINA'S MEDICAID  
3 PROGRAM THROUGH PROVIDER-LED CAPITATED HEALTH PLANS.

4 The General Assembly of North Carolina enacts:

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

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

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

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

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

- 32 (1) Provider-led entities shall implement full-risk capitated health plans to  
33 manage and coordinate the care for enough program aid categories to cover  
34 at least ninety percent (90%) of Medicaid recipients to be phased in over five  
35 years from the date this act becomes law. Program aid category coverage



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1 shall not include dual eligibles for whom Medicaid pays only Medicare  
2 premiums. In aggregate, provider-led entities shall cover Medicaid recipients  
3 in all 100 counties.

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

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

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

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

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

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

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

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

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

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

39 (1) Within 12 months of this act becoming law, the Department shall develop,  
40 with meaningful stakeholder engagement, and submit to CMS a request for a  
41 1115 Medicaid demonstration waiver to implement the components of this  
42 act.

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

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

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

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

7 **SECTION 5.** Submission of Waiver. – The Department shall submit to CMS the  
8 1115 waiver and any other waivers and State Plan amendments necessary to accomplish the  
9 requirements of this act within the required time frames.

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

- 13 (1) No bid may be considered if it does not, at a minimum, provide for all of the  
14 following:  
15 a. Cover a defined population of at least 30,000 recipients.  
16 b. Ensure appropriate access to care for recipients.
- 17 (2) Individually, bidders must:  
18 a. Agree to receive risk-adjusted capitation rates for all health benefits  
19 and administrative services, including physical, long-term services  
20 and supports, and other medical services generally considered  
21 physical care.  
22 b. Agree to transition to full-risk capitation for all services and related  
23 administrative costs for enrolled populations within the three to five  
24 years following the enactment of this act.  
25 c. Agree to defined measures for risk-adjusted health outcomes, quality  
26 of care, patient satisfaction, and costs.  
27 d. Meet financial solvency requirements developed by the Department  
28 of Insurance that are equivalent to the solvency requirements for  
29 health maintenance organizations in G.S. 58-67-110.  
30 e. Assume responsibility for complying with appeal rights and program  
31 integrity functions.  
32 f. Meet all data systems standards.
- 33 (3) Collectively, bidders are responsible for:  
34 a. Coverage for all 100 counties.  
35 b. Managing ninety percent (90%) of the State's Medicaid population  
36 within five years of enactment. All dual eligibles shall be excluded.  
37 c. A reduction of at least two percentage (2%) points below the national  
38 Medicaid spending growth as documented and projected in the  
39 annual report prepared for CMS by the Office of the Actuary for  
40 nonexpansion states.
- 41 (4) All contracts must:  
42 a. Include clear performance goals based on the defined measures that  
43 are monitored and measured at specified and appropriate intervals.  
44 b. Provide penalties for failure to meet the performance goals.  
45 c. Provide financial rewards for achieving performance goals.  
46 d. Be for a term of five years with options to renew or extend based  
47 upon successful performance, as determined by the Department and  
48 contained in the contract.  
49 e. Adhere to the quality standards that are developed by the Quality  
50 Assurance Advisory Committee and are consistent with State and  
51 national quality measures.

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

- 10           (1) Establish procedures and criteria for certifying that contracts entered into  
11           under Section 6 of this act establish an adequate medical services delivery  
12           network, including determining criteria to ensure Medicaid recipients have  
13           access to all medically necessary services.
- 14           (2) Establish quality standards and minimum services delivery network  
15           requirements for contracts entered into under Section 6 of this act.
- 16           (3) Ensure recipients have appropriate access to primary care and specialty care  
17           services and shall develop a rate floor for this purpose.
- 18           (4) Establish and implement quality assurance measures for the contracts  
19           entered into under Section 6 of this act.
- 20           (5) Adopt and implement requirements for the contracts entered into under  
21           Section 6 of this act concerning Health Information Technology, robust data  
22           analytics, quality of care, and care-quality improvement.
- 23           (6) Ensure that providers are required to manage care under appropriate  
24           evidence-based standards of care to more efficiently manage utilization and  
25           clinical resources.
- 26           (7) Encourage providers to utilize appropriate technologies, such as  
27           telemedicine, to provide expeditious care and ensure access to services.
- 28           (8) Establish procedures for termination of a contract entered into under Section  
29           6 of this act for nonperformance of contractual duty or failure to meet or  
30           maintain benchmarks, standards, or requirements provided by this act or  
31           established by the Department.

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

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

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

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

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

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

5   "Article 23B.

6   "Joint Legislative Oversight Committee on Medicaid.

7 **"§ 120-209. Creation and membership of Joint Legislative Oversight Committee on**  
8 **Medicaid.**

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

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

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

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

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

23 **"§ 120-209.1. Purpose and powers of Committee.**

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

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

29 **"§ 120-209.2. Organization of Committee.**

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

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

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

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

44 **"§ 120-209.3. Additional powers.**

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

49 **"§ 120-209.4. Reports to Committee.**

50           Whenever the Department is required by law to report to the General Assembly or to any of  
51 its permanent, study, or oversight committees or subcommittees on matters affecting the

1 Medicaid or NC Health Choice programs, the Department shall transmit a copy of the report to  
2 the cochairs of the Joint Legislative Oversight Committee on Medicaid."

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

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

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