2015 Medicaid Reform Proposal Comparison Document

Comparison Chart of Medicaid Reform Features:

	Senate ***HB 97, 7th Edition, Section 12H.24***	**House** ***HB 372, 3rd Edition***
Who conducts reform?	New Health Benefits Authority (independent agency)	Existing Department of Health and Human Services, advised by newly created Quality Assurance Advisory Committee
Basic goal	"…transform the State's current Medicaid program to a system that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need."	Same
Payment structure	Full-risk capitated health plans	Same
Who can contract for payment?	Provider-Led Entities (PLEs) and Managed Care Organizations (MCOs) ***PLE will be defined by the Health Benefits Authority, but a majority of the PLE's board must be providers or entities composed of providers*	Provider-Led Entities (PLEs) only ***PLE is defined as either a provider, an entity that owns providers, or an entity owned by providers*
Geographical coverage of contracts	3 Statewide contracts and up to 12 regional contracts in 6 regions to be set by the Authority	Individual contracts must cover at least 30,000 lives and may cover less than the entire state; contracts in aggregate must cover entire state
Covered populations	All Medicaid beneficiaries except the dual-eligible categories for whom Medicaid pays only Medicare premiums	90% of all Medicaid beneficiaries statewide; excludes dual eligibles
Covered services	All services, except LME/MCO services will be a pass-through contract during the first 3 years; no primary care case management	All services except LME/MCO services, dental, and drugs/pharmacy; builds on existing enhanced primary care medical home model
Timeline for implementation	Full implementation by August 1, 2017 (approx. 2 years)	Full implementation of capitated payments within 5 years of enactment (approx. 2020); Performance and quality goals must be met within 6 years of enactment (approx. 2021)
Legislative Oversight	New Legislative Oversight Committee on the Health Benefits Authority	New Legislative Oversight Committee on Medicaid

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July 1, 2015

Features of Senate Proposed Health Benefits Authority:

- The **Health Benefits Authority would be a new agency, independent of the Department of Health and Human Services** (DHHS), managed by a **compensated board of experts** in the administration of large health delivery systems, health insurance, health actuarial science, health economics, and health law and policy.
- **Effective October 1, 2015, the Health Benefits Authority would become the Medicaid single state agency**, and would have **broad authority to administer and operate the Medicaid and Health Choice programs** and set all program components except for eligibility categories and income thresholds.
- The **Health Benefits Authority would enter into an agreement with DHHS for continued operation of the Medicaid and Health Choice programs until transformation is complete in August 2017**, and the Authority would supervise DHHS's operation of the programs.
- The **Health Benefits Authority would plan for and implement the Medicaid transformation** plan outlined in the special provision, including requesting necessary waivers and state plan amendments.
- **DHHS would identify from among its current employees those who are "essential" to operating the current Medicaid program**, and those employees would be eligible **to receive bonus payments** for continuing to operate the current Medicaid program through the transformation process. Upon completion of transformation, **DHHS employees would not automatically transfer to the Health Benefits Authority**.
- The Health Benefits Authority would **hire the Medicaid Director** and other staff, and **Authority staff would be exempt from the State Personnel Act** (now NC Human Resources Act). **Certain employees would be subject to a cooling off period** before accepting employment with an entity under contract with the Authority.
- The Health Benefits Authority would have the following additional responsibilities:
    - Increased responsibility to **keep Medicaid within its budget**, to annually provide **4-year forecasts**, and access to a **Medicaid Reserve Account** if certain conditions are met.
    - Required **strategic planning and performance measurement**.
    - **Increased transparency and reporting** of performance measures, audited financial statements, and enrollment and spending data.
- Other features of the Board include:
    - **7 voting members** (3 appointed by the Governor, 2 by the Senate, and 2 by the House), and the **Secretary of DHHS would be a nonvoting, ex oficio**, Board member.
    - An individual would be excluded from service on the Board if he or she is, or within the past six months had been, a Medicaid provider, a lobbyist for Medicaid providers, or a state employee.
    - **Compensation paid to Board members would be comparable to the compensation paid to the members of boards operating large health insurance plans**, not to exceed the highest compensation paid to ta member of the Council of State. Initially, compensation would be set by the Office of State Human Resources, and subsequently, the Board would set its own compensation.