GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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HOUSE BILL 1181
PROPOSED COMMITTEE SUBSTITUTE H1181-PCS40251-ME-17

Short Title: North Carolina Medicaid Modernization. (Public)

Sponsors:

Referred to:

May 22, 2014

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 Medicaid program from a traditional fee-for-service system into a system 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) Provide budget predictability.
(2) Slow the rate of cost growth.
(3) Achieve cost-savings through efficient reductions in programmatic costs.
(4) Create more efficient administrative structures.
(5) Improve health outcomes for the State's Medicaid population.
(6) Require provider accountability for budget and program outcomes.

SECTION 2. Building Blocks. – The principal building blocks of the Medicaid transformation directed by Section 1 of this act shall be as follows:

(1) A delivery system that builds upon the State's primary care medical home model, as primary care providers serve an integral role in improving the health of Medicaid beneficiaries.
(2) Provider-led capitated health plans to manage and coordinate the care for the majority of the Medicaid population by July 1, 2020, subject to the following:
    a. The plans shall begin with limited risk but shall assume greater amounts of risk over time to transition into fully capitated health plans that receive a capitated payment for the delivery of medical services, providing services for enrolled beneficiaries at an established cost.
    b. When the capitated plans are fully implemented, the State shall maintain only the risk of enrollment numbers and enrollment mix for the capitated populations.
    c. Plan coverage areas shall be based on the primary care case management regions used by Community Care of North Carolina (CCNC).
(3) Mechanisms to encourage personal accountability for Medicaid beneficiaries' participation in their own health outcomes.

(4) Strong performance measures and metrics to hold providers accountable for quality.

SECTION 3. DHHS to Lead. – The Department of Health and Human Services, Division of Medical Assistance, shall begin the statewide restructuring of the State Medicaid Program by transitioning the traditional fee-for-service system into a system of provider-led capitated health plans. The new system shall meet the goals listed in Section 1 of this act and shall include the building blocks listed in Section 2 of this act.

SECTION 4. Development of Detailed Plan. – The Department of Health and Human Services, Division of Medical Assistance, shall develop with stakeholder input a detailed plan for Medicaid transformation that meets the goals listed in Section 1 of this act and includes the building blocks listed in Section 2 of this act. The plan shall provide for systematic, phased-in implementation of changes to the State's Medicaid system and shall include the following:

(1) Proposed time frames for implementing system transformation on a phased-in basis and the recommended effective date for full implementation of all recommended changes.

(2) An estimate of the amount of State and federal funds necessary to implement the changes. The estimate should indicate costs of each phase of implementation and the total cost of full implementation.

(3) An estimate of the amount of long-term savings in State funds expected from the changes. The estimate should show savings expected in each phase of implementation and the total amount of savings expected from full implementation.

(4) Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.

(5) Mechanisms for measuring the State's progress toward increased performance on the following:

a. Budget predictability.

b. Access to services.

c. Consumer-focused outcomes and accountability.

d. Promotion of evidence-based best practices.

e. Quality management systems.

f. System efficiency and effectiveness.

SECTION 5. Report of Detailed Plan. – By March 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall report to the General Assembly the Division's strategic plan for the Medicaid transformation required under Section 4 of this act. If a detailed plan cannot reasonably be completed by March 1, 2015, the Division shall (i) inform the report recipients by February 1 that the March 1 report will be a progress report and (ii) provide by March 1 an update on the progress toward completing a plan and report on the portions of the plan that have been completed. Such a report or update shall be submitted to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 6. Semiannual Report. – Beginning September 1, 2015, and every six months thereafter until a final report on September 1, 2020, the Secretary shall report to the Joint Legislative Oversight Committee on Health and Human Services on the State's progress toward completing Medicaid transformation.

SECTION 7. Maintain Funding Mechanisms. – In developing its detailed plan under Section 4 of this act, the Department of Health and Human Services, Division of Medical Assistance, shall work with the Centers for Medicare & Medicaid Services (CMS) to preserve

existing Medicaid-specific funding streams, such as assessments, as they currently exist. If such Medicaid-specific funding cannot be maintained as currently implemented, then the Division shall advise the General Assembly of the modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, then the Division shall include that information in the cost estimates for Medicaid transformation. Additionally, such funding streams should be modified so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals.

SECTION 8. Waivers and SPAs. – The Department of Health and Human Services shall apply to the Centers for Medicare & Medicaid Services (CMS) for any waivers, including Section 1115 waivers, or State plan amendments as may be necessary to implement and secure federal financial participation in the Medicaid transformation required by this act.

SECTION 9. General Assembly Commitment. – The General Assembly recognizes and hereby commits to allowing the time and providing the funding necessary to implement the Medicaid transformation required by this act.

SECTION 10. LME/MCO Integrated Care Demonstration. – As part of the transformation of the Medicaid system, the Department of Health and Human Services, Division of Medical Assistance, shall establish a demonstration pilot program to provide for a single payment for the full array of Medicaid services to recipients currently enrolled under the 1915(b)/(c) Medicaid waiver. The purpose of the demonstration pilot is to test whether existing local management entities that have been approved to operate as managed care organizations (LME/MCOs) can successfully unite the management of physical and behavioral health care through a single payment, subject to the following requirements:

(1) Only LME/MCOs that have successfully managed the 1915(b)/(c) Medicaid waiver for a minimum of five years and that are meeting contract and S.L. 2013-85 requirements shall be eligible to operate the pilot.

(2) An LME/MCO operating the pilot shall be responsible for managing all Medicaid services for eligible recipients in accordance with the requirements of the 1915(b)/(c) Medicaid waiver.

(3) Medicaid services for recipients who are eligible for enrollment in the 1915(c) North Carolina Innovations Waiver, but who instead reside in intermediate care facilities for individuals with mental retardation (ICF/MRs), shall be included in the pilot.

The Division shall report to the Joint Legislative Oversight Committee on Health and Human Services no later than November 1, 2015, on the initiation of the pilot. The Department shall provide additional status reports annually for the following three years no later than November 1 of each year. The report shall address the pilot's impact, as compared to the existing fee-for-service Medicaid Program, on both providers and recipients in areas such as access to services, quality of care, and cost, as well as any other areas of comparison helpful to evaluate the pilot's impact.

SECTION 11. This act is effective when it becomes law.