# HOUSE BILL 372:
# 2015 Medicaid Modernization

**This Bill Analysis reflects the contents of the bill as it was presented in committee.**

*2015-2016 General Assembly*

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| **Committee:** | House Health, if favorable, Appropriations | **Date:** | June 10, 2015 |
| **Introduced by:** | Reps. Dollar, Lambeth, B. Brown, Jones | **Prepared by:** | Kory Goldsmith<br>Staff Attorney |
| **Analysis of:** | PCS to First Edition<br>H372-CSTR-1 | | |

***SUMMARY: The Proposed Committee Substitute to HB 372 would transition the Medicaid and NC Health Choice programs from fee-for-service to full-risk capitated health plans operated by provider-led entities to manage and coordinate the care for enough program aid categories to cover at least 90% of Medicaid and NC Health Choice recipients within five years of the act becoming law. All physical health services would be included in the coverage except dental and pharmacy. The Department of Health and Human Services (Department) would manage and administer the program within the budget appropriated by the General Assembly. Once fully implemented, the State would retain only the risk of enrollment numbers and enrollment mix of populations receiving services.***

**BILL ANALYSIS:**

**Section 1** sets out the intent of the General Assembly which is to transform the current Medicaid program so that it provides budget predictability while ensuring quality of care.

**Section 2** provides definitions including the following:

- Capitation payment – A payment the State agency periodically makes to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.
- Provider – An individual or business entity required to enroll in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children to provide services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient.
- Provider-led entity (PLE) – A provider, an entity with the primary purpose of owning or operating one or more providers, or a business entity in which providers hold a controlling ownership interest. In addition, a majority of each PLE's governing board must be comprised of physicians who treat Medicaid and NC Health Choice patients.
- Recipient – An individual who has been determined to be eligible for Medicaid or NC Health Choice.

**Section 3** sets out the structure of the transformed Medicaid and NC Health Choice programs which shall include:

- Implementation of full-risk capitated health plans by provider-led organizations to be phased in over five years from the date the act becomes law. The health plans would include enough program aid categories to cover at least 90% of Medicaid recipients in all 100 counties.
- Once fully implemented, the State retains the budgetary risk of enrollment numbers and enrollment mix of populations for which capitated payments are made.

- PLE contracts control the State's cost growth to at least 2% below national Medicaid spending growth based on the CMS annual report for nonexpansion states.
- Administrative costs are minimized and the Department shall establish medical loss ratios which allocate at least 90% of the capitated payment to patient care.
- PLEs will be responsible for all administrative functions including claims processing, appeals, and care and case management.

**Section 4** sets out the following timeline for implementation:

- Within 1 year of the act becoming law, the Department must submit an application for an 1115 Medicaid demonstration waiver.
- Within 2 years of the act becoming law and approval by CMS of the demonstration waiver, the Department must issue a request for proposals (RFP) for provider-led organizations to bid on contracts.
- Within 5 years of the act becoming law, 90% of recipients will be enrolled in full-risk, capitated health plans for all services except those provided by LME/MCOs, dental and pharmacy.
- Within 6 years of the act becoming law, each PLE must meet the risk, cost, performance, and quality goals set by the act and the contract.

**Sections 5 and 10(b)** directs the Department to submit the 1115 demonstration waiver and to continue implementing the existing 1915(b)/(c) waiver.

**Section 6** sets out the minimum requirements for the RFPs and contracts. In addition to the mandatory components described above, each contract must cover at least 30,000 recipients, ensure appropriate access to care for recipients, and include defined measures of critical metrics. Collectively, the contracts must cover all 100 counties. All successful PLEs must meet the solvency requirements set by the Department of Insurance for health maintenance organizations. All contracts must be for 5 years and must contain clear performance goals with penalties for failure to meet the goals and financial rewards for meeting the goals.

**Section 7** delegates to the Department full authority to implement the transformation of the Medicaid and NC Health Choice programs, including the authority to hire individuals with the experience and competencies to manage the Medicaid and NC Health Choice programs in a contract environment.

**Section 8** directs the Secretary of the Department to convene an advisory committee of experts to advise the Department on the development of the 1115 waiver application and on the performance goals to be contained in the contracts.

**Section 9** requires periodic audits of the plans.

**Section 10** directs the Department to work with CMS to preserve existing levels of funding.

**Section 11** creates the Joint Legislative Oversight Committee on Medicaid which would oversee the transformation. It would be composed of 7 members from the Senate, 7 members from the House of Representatives, and 2 members from each chamber would be members of the minority party.

**Section 12** appropriates $2.5 million of non-recurring funds to the Department for the 2015-16 and the 2016-17 fiscal years to provide a State match for federal funds to pay for Medicaid transformation.

**EFFECTIVE DATE:** Section 12 of the bill becomes effective upon appropriation by the General Assembly of the funds for implementation of the act. The remainder of the act is effective when it becomes law.