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

2015-2016 General Assembly

HOUSE BILL 372: Medicaid Transformation/HIE/PrimaryCare/Funds

Committee:	Senate Appropriations/Base Budget	**Date:**	August 7, 2015
Introduced by:	Reps. Dollar, Lambeth, B. Brown, Jones	**Prepared by:**	Jennifer Hillman* Staff Attorney
Analysis of:	Fourth Edition		

SUMMARY: House Bill 372 would change the operational structure and administrative oversight for the Medicaid and NC Health Choice programs, enact the Statewide Health Information Exchange (HIE) Act, and provide for the discontinuation of the Medicaid primary care case management (PCCM) program. The new Medicaid and Health Choice programs would feature: full-risk capitated payments to commercial insurers and provider-led entities (PLEs); management by a newly created Department of Medicaid; and oversight by a newly created Joint Legislative Oversight Committee. The HIE Act would require participation from specified providers and create both an HIE Authority and an HIE Advisory Board. The current Medicaid PCCM program would be discontinued to provide funding for increased Medicaid rates to primary care physicians.

CURRENT LAW: Section 1 pertains to the **Medicaid Transformation and Reorganization**, **Section 2** pertains to the **Statewide Health Information Exchange**, and **Section 3** pertains to **Medicaid Primary Care Case Management**. The various Sections of the bill have been outlined below.

Medicaid Transformation - Section 1 of the bill addresses the plan for Medicaid transformation. The plan features full-risk capitated contracts with commercial insurers and provider-led entities, which would be responsible for the provision of all services to all Medicaid and Health Choice beneficiaries except dual eligibles. A newly-created independent agency, the Department of Medicaid (DOM), would oversee the transition and would become the single state agency responsible for the programs on January 1, 2016. The Department of Health and Human Services (DHHS) would continue to operate the current Medicaid and Health Choice programs until the transition to capitated payments is complete.

Section 1(a) outlines the intent and goals of the transformation. **Section 1(b)** outlines the structure of the delivery system which requires contracts with Medicaid managed care organizations (MCOs), which is defined to include commercial insurers and provider-led entities (PLEs). **Section 1(c)** provides a timeline for the transformation. **Section 1(d)** outlines the following components: Requests for Proposals (RFP); bid submission; terms and conditions of contracts. **Section 1(e)** requires a monthly progress report, from February 1, 2016 through January 1, 2019, to a newly created Joint Legislative Oversight Committee on Medicaid (LOC on Medicaid). **Section 1(f)** requires working with the Centers for Medicare and Medicaid Services (CMS) to preserve existing funding streams, such as assessments, with a goal of ensuring that funding streams are more closely aligned to improving health outcomes and achieving Medicaid goals. **Section 1(g)** outlines the role of the Department of Health and Human Services (DHHS) in the transformation including: agreements for supervision of the program's administration during the transition; organization and identification of a stabilization team; identification and designation of "essential positions" necessary for day-to-day operation and the provision of certain benefits for those employees; and a prohibition on DHHS from entering into contracts without approval by the new DOM. **Sections 1(h)** pertains to the creation of a new cabinet-level department to administer

and operate the Medicaid and NC Health Choice programs and provides for the transfer of all functions, powers, duties, obligations and services vested in the DHHS Division of Medical Assistance (DMA) to the new DOM**. Section 1(i)** amends Chapter 143B of the General Statutes to create a new Article 14 to create the new Department of Medicaid (DOM). The new Article creates the DOM, outlines the powers and duties of the Secretary of Medicaid, provides for variations from certain State laws, specifies the cooling off period for certain employees, and establishes a Medicaid Reserve Account. **Section 1(j)** provides that effective January 1, 2016, all rules and policies exempted from rule making related to Medicaid and NC Health Choice programs will transfer to the DOM and that a May 1, 2016 report to the LOC on Medicaid must include recommendations for additional rule-making requirements under Chapter 150B of the General Statutes. **Sections 1(k) and (k1)** pertain to legal actions involving Medicaid and NC Health Choice programs and provide that the Commissioner of Insurance shall establish solvency requirements for the MCOs and PLEs referenced in this bill. **Section 1(l)** establishes a Joint Legislative Oversight Committee on Medicaid consisting of 14 members charged with examining the budgeting, financing, administrative, and operational issues related to Medicaid and NC Health Choice Programs. **Section 1(m)** makes a conforming change for the newly created LOC on Medicaid to amend G.S. 120-208.1(a)(2)b removing oversight of "Medical Assistance" from the purview of the Joint Legislative Oversight Committee on Health and Human Services. **Section 1(n)** directs the Revisor of Statutes to recodify existing law to reflect the structure reflected by the changes in this bill. **Section 1(o)** amends G.S. 108A-1 to make changes conforming to this bill. **Section 1(p)** amends G.S. 108A-54.1A to provide that the DOM is authorized and required to take any and all necessary action to amend the Medicaid State Plan and waivers in order to keep the program within the certified budget. **Section 1(q)** repeals G.S. 108A-54.2(d) which currently imposes limitations on DHHS's ability to change medical policy unless directed by the General Assembly. **Section 1(r)** creates G.S. 108E-2-1 to provide that the General Assembly sets eligibility categories and income thresholds and G.S. 108E-2-2 to provide that counties determine eligibility in accordance with Chapter 108A. **Section 1(s)** amends G.S. 126-5 to exempt employees of the DOM from all but Article 6 (Equal Employment and Compensation Opportunity, Assisting in Obtaining State Employment) and Article 7 (Privacy of State Employee Personnel Records) of the State Human Resources Act. **Sections 1(t) and (u)** amend G.S. 143B-153 and G.S. 150B-1 to make conforming changes utilizing the DOM name. **Section 1(v)** appropriates $5,000,000 in recurring funds for the 2015-16 and 2016-17 fiscal years to accomplish the transformation. The funds provide a State match for $5,000,000 in federal funds. **Section 1(w)** provides Section 1(n) through Section 1(u) become effective January 1, 2016 and the remainder of Section 1 is effective when it becomes law.

The following chart compares key features of the Fourth Edition of the bill to the Third Edition:

	Fourth Edition (Senate)	**Third Edition (House)**
Who conducts reform?	New Department of Medicaid (DOM) ***an independent agency, headed by a Secretary appointed by the Governor and confirmed by the General Assembly*	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

	Fourth Edition (Senate)	Third Edition (House)
Who can contract for payment?	Provider-led entities (PLEs) and commercial insurers	Provider-led entities (PLEs) only
Geographical coverage of contracts	3 statewide contracts and up to 12 regional contracts in 5-8 regions to be set by the new DOM	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 dual-eligible categories	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 initial contract period; 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 12 months after approval of the plan by the federal government, with submission of documents to the federal government required by May 1, 2016	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 Medicaid	same

Statewide Health Information Exchange - **Section 2** of the bill addresses the plan for the Statewide Health Information Exchange (HIE) Network. **Section 2(a)** provides the intent of the General Assembly with regard to the HIE**. Section 2(b)** appropriates $8,000,000 in recurring funds for the 2015-16 and 2016-17 fiscal years to continue efforts toward the implementation of a statewide health information exchange network. The Secretary of DHHS and the State Chief Information Officer (CIO) must enter into a memorandum of understanding (MOU) so that the State CIO will have sole authority to direct the expenditure of funds appropriated to DHHS for the statewide health information exchange until such time as (i) the NC HIE Authority is established and the State CIO has appointed an Authority Director, and the NC HIE Advisory Board is established. **Section 2(c)** directs that once the HIE Authority Director has been hired and Advisory Board members have been appointed, the HIE Authority will assume responsibility for the funds appropriated to DHHS and can expend the funds for specified tasks, including facilitating the termination of or assignment to the Authority of all contracts pertaining the State's existing HIE Network by December 31, 2015. **Section 2(d)** amends Chapter 90 of the General Statutes to add a new Article 29B. Statewide Health Information Exchange Act. The new Act mirrors the NC Health Information Exchange Act, but expands mandatory participation in the successor HIE Network beyond just hospitals with electronic health record systems to Medicaid providers and all providers that receive State funds for the provision of health services. Receipt of State funds, including Medicaid funds, is conditioned upon these entities fulfilling the mandatory participation requirements. The Statewide Health Information Exchange Act includes the following components: purpose; definitions; required participation in the HIE Network for some providers; State ownership of data disclosed through HIE Network; creation of the NC HIE Authority; creation of the NC HIE Advisory Board; participation by covered entities; right to opt out, effect of opt out, exception for emergency medical treatment; construction and applicability; penalties and remedies. **Section 2(e)** amends G.S. 126-5 to exempt employees of the North Carolina Health Information Exchange Authority from all but

Article 6 (Equal Employment and Compensation Opportunity, Assisting in Obtaining State Employment) and Article 7 (Privacy of State Employee Personnel Records) of the NC Human Resources Act. **Section 2(f)** repeals Article 29A of Chapter 90 which is the current North Carolina Health Information Exchange Act. **Section 2(g)** sets out the effective dates for Section 2. It provides that Section 2(d) and Section 2(e) become effective October 1, 2015. Section 2(f) becomes effective on the date the State CIO notifies the Revisor of Statutes that all contracts pertaining to the HIE Network (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties have been terminated or assigned to the NC HIE Authority. The remainder of the section becomes effective July 1, 2015.

Medicaid Primary Care Case Management - **Section 3** of the bill addresses the current Medicaid and NC Health Choice primary care case management (PCCM) program. **Section 3(a)** directs the discontinuation of the PCCM program effective May 1, 2016 and prohibits renewal of the current contract for PCCM with North Carolina Community Care Networks, Inc, (NCCCN) beyond April 30, 2016. **Section 3(b)** directs DHHS to submit a State Plan amendment to the federal government no later than February 1, 2016 to discontinue the PCCM program and directs DHHS to discontinue payments related to the PCCM program effective May 1, 2016 unless and until the state plan amendment is denied. **Section 3(c)** clarifies that DHHS may develop or utilize contracts for managed care other than PCCM after May 1, 2016. **Section 3(d)** makes a conforming change to G.S. 108A-70.21(b) governing NC Health Choice. **Section 3(e)** increases the Medicaid rate paid to primary care physicians to 100% of Medicare rates effective May 1, 2016. **Section 3(f)** makes findings regarding savings to the Medicaid program related to discontinuing the PCCM program and the NCCCN contract and appropriates funds to be used to increase rates to primary care physicians and to directly fund local health departments' continued services related to the Care Coordination for Children (CC4C) program, previously funded through the contract with NCCCN.

EFFECTIVE DATE: The effective dates have been provided within the summary. Except as otherwise provided, this act is effective would become when it becomes law.

**Theresa Matula, Senate Health Committee Staff, and Joyce Jones, Staff Attorney with the Legislative Drafting Division, substantially contributed to this summary.*