FILED SENATE
Mar 26, 2015
S.B. 568
PRINCIPAL CLERK

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE DRS25150-MM-40 (02/19)

Short Title:	North Carolina Health Care Modernization.	(Public)
Sponsors:	Senator Tarte (Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE AND TRANSFORM HEALTH CARE PURCHASING IN NORTH CAROLINA AND TO CONSOLIDATE THE LME/MCO REGIONS.

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 health care purchasing methods from a traditional fee-for-service system into a value-based system that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new purchasing program shall be designed to achieve the following goals:

(1) Provide budget predictability and stability.
(2) Achieve cost savings through improved population health.
(3) Appropriately value primary care as the foundational level of health care required by all North Carolinians.
(4) Jointly incentivize patients and providers in pursuit of better health.
(5) Improve access and choice for beneficiaries in a market-driven environment.

Once reform is fully implemented, the State's budget variability shall be limited to the variations in enrollment numbers and patient mix for the capitated populations.

SECTION 2. Building Blocks. – The principal building blocks of purchasing reform directed by this act shall be as follows:

(1) Patient Population. – The Patient Population will be patients participating in North Carolina Medicaid, NC Health Choice and the North Carolina State Health Plan.
(2) Primary Care Medical Homes (PCMHs). – PCMHs will serve the primary care needs of the Patient Population in exchange for a periodic payment for a defined menu of services.
(3) At-Risk Provider-Led Organizations (ARPLOs). ARPLOs are capitated health plans administered by North Carolina's provider-led Accountable Care Organizations that will manage and coordinate the care for the Patient Population, outside of the PCMHs, pending waiver approval where appropriate for this transformation by the Center for Medicare & Medicaid Services.
(4) Plan Administrators. – The Plan Administrators[not defined, not clear who picks them or how they are regulated] for the Patient Population will implement the administration of the primary care centric purchasing strategy and incentive-driven plan design designated in Section 4 of this act for its beneficiaries.

(5) Licensed Commercial Health Insurers (LCHIs). – LCHIs will offer insurance plans based on the primary care centric purchasing strategy and incentive-driven plan design designated in Section 4 of this act to individuals and groups. One or more Commercial Health Insurers will be designated to offer this plan to newly eligible North Carolina Medicaid beneficiaries, pending waiver approval for this transformation by the Center for Medicare & Medicaid Services. In all other aspects, these newly eligible Medicaid beneficiaries will be treated the same as the Patient Population.

(6) Cooperation between ARPLOs and LME/MCOs. – ARPLOs are authorized under this act to work in collaboration with the LME/MCOs to serve the appropriate Patient Population. As such:

a. ARPLOs may coordinate care offered by employed or independent providers under mutually agreeable terms. Notwithstanding the foregoing, no ARPLO may interfere with an independent provider's ability to contract with another ARPLO offering services in the same region.

b. If multiple plans cannot be established for a rural area, then, as allowed by 42 C.F.R. 438.52, those rural areas may operate with one plan.

c. ARPLOs that contract to cover a rural area may be awarded a contract to cover an urban area that is contingent upon continued coverage in the rural area.

(7) Risk adjusted capitated rates based on eligibility categories, geographic areas, and clinical risk profiles of recipients.

(8) Participant choice of plans offering customized benefit packages that appeal to and meet the varied health needs of participants.

(9) NC Health Score [not defined – what is this and who operates it] shall establish metrics to provide incentives and encourage personal accountability for beneficiaries' participation in their own health outcomes.

(10) Mechanisms to identify recipients who may benefit from other services and programs to maximize their opportunities for self-improvement.

(11) NC Health Score [same question as above] will provide performance measures and metrics to hold providers accountable for quality outcomes.

SECTION 3. Definitions. – As used in this act, the following definitions apply:

(1) Primary Care Medical Home (PCMH). – An individual or other legal entity that is licensed, registered, or otherwise authorized to provide Primary Care Services in this State under North Carolina laws. Primary Care Provider includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.

(2) Primary Care Medical Home Agreement (Agreement). – A contract between a Primary Care Provider and an individual patient, his or her legal representative, or a plan sponsor of a qualifying benefit plan as defined in Section 4 of this act in which the health care provider agrees to provide Primary Care Services to the individual patient or plan beneficiary of the patient population for an agreed-upon fee and period of time. A primary care medical home agreement is not insurance and is not subject to North Carolina insurance regulations. Entering into an agreement is not creating any health plan that might be regulated by ERISA. To be considered an agreement for the purposes of this act, the agreement must meet all of the following requirements:

a. Be in writing.

b. Be signed by the Primary Care Provider or agent of the Primary Care Provider and the individual patient, his or her legal representative, or the administrator of the appropriate patient population.
c. Allow either party to terminate the agreement on written notice to the other party.
d. Describe the scope of Primary Care Services that are covered by the periodic fee.
e. Specify the periodic fee and any additional fees outside of the periodic fee for ongoing care under the agreement.
f. Specify the duration of the agreement.

(3) Primary Care Service. – Includes, but is not limited to, the screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of disease or injury within the competency and training of the Primary Care Provider.

SECTION 4. Development of Detailed Plan. – The Department of Health and Human Services (DHHS) shall develop, with stakeholder input, a detailed plan for purchasing reform 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 strategic changes to the Patient Population and shall include the following:

(1) Proposed waivers where appropriate, including Section 1115 waivers, or State Plan Amendments (SPAs) as may be necessary to implement and secure federal financial participation in the Medicaid reform required by this act.
(2) Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.
(3) 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.
(4) 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 on an annual basis.
(5) The details of the two-year risk phase-in for the provider-led capitated plans in the appropriate Patient Population.
(6) The regions defined by DHHS/Department of Medical Benefits, any population or provider thresholds used in defining regions, and the number of expected plans per region and how many are expected to be provider-led and nonprovider-led.
(7) Any populations or diseases for which specialty plans may be established.
(8) Mechanisms for measuring the State's progress towards the reform goals listed in Section 1 of this act.
(9) In consultation with Community Care of North Carolina (CCNC), the quality metrics for evaluating provider and health plan success.
(10) Strategies for ensuring fair negotiations among provider led plans, nonprovider-led plans, providers, and the DHHS.
(11) A recommendation of any existing State contracts that could be effected by this act.
(12) Methods to ensure that DHHS will (i) enter into contracts that are advantageous to the State and (ii) properly manage the contracts to hold contractors accountable.

(13) A strategy for program integrity, including how NC Health Score [not defined] and the health plans will work together to ensure that State dollars are spent appropriately.

(14) A robust information technology infrastructure design, including strategies to (i) transfer existing data and resources at DHHS, (ii) monitor performance of health plans, and (iii) provide information to and receive information from service providers.

(15) Plans to interact with other State agencies in areas such as communications with the Centers for Medicare & Medicaid Services (CMS) prior to becoming the single State entity, eligibility determinations, the allocation of Medicaid-related costs to the Medicaid program, the interaction of the new Medicaid program with other State information technology systems, and other issues that will require coordination with other State agencies.

SECTION 5. Report of Detailed Plan. – By April 15, 2015, DHHS shall report to the General Assembly [suggest a more specific entity to report to, like HHS Oversight Committee or Fiscal Research – reports to the GA aren't owned or monitored by anyone and fall through the cracks] its strategic plan for the Medicaid reform required under Section 4 of this act. If a detailed plan cannot reasonably be completed by April 15, 2015, DHHS shall (i) inform the report recipients by March 15 that the April 15 report will be a progress report and (ii) provide by April 15 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 Joint Legislative Oversight Committee on Medical Benefits 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 DHHS and other Administrators shall report to the General Assembly [same issue as above] on the State's progress toward completing transformation in the Patient Population. Reports shall be due to the Joint Legislative Oversight Committee on Medical Benefits.

SECTION 7. Maintain Funding Mechanisms. – In developing its detailed plan under Section 4 of this act, the Department shall work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. This work with CMS shall be facilitated by the Department of Health and Human Services, Division of Medical Assistance. If such Medicaid-specific funding cannot be maintained as currently implemented, then DHHS shall advise the General Assembly [same issue as above] of the modifications necessary to maintain as much revenue as possible within the context of Medicaid reform. If such Medicaid specific funding streams cannot be preserved through the reform process or if revenue would decrease, then DHHS shall include that information in the cost estimates for Medicaid reform. 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. Chapter 120 of the General Statues is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on Primary Care and Medical Benefits.

"**§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Primary Care and Medical Benefits.**

(a) The Joint Legislative Oversight Committee on Primary Care and Medical Benefit is established. The Committee consists of 14 members as follows:

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

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

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

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

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

(a) The Joint Legislative Oversight Committee on Primary Care and Medical Benefits shall examine budgeting, financing, administrative, and operational issues related to the following:

(1) The reform of purchasing primary care for Medicaid and the State Health Plan.

(2) Monitoring the effectiveness of engagement strategies and outcomes produced by authorized primary care medical homes, ACO, and Commercial Plans.

(3) Review of criteria for establishing minimum benefits to be provided by primary care medical homes and the value of periodic payments made to providers.

(4) Review effectiveness and financial performance of State Health Plan in conjunction with the Treasurer's office and State Health Plan Board of Directors.

(b) The Committee may make interim reports to the General Assembly on matters for which it may report to a regular session of the General Assembly. A report to the General Assembly may contain any legislation needed to implement a recommendation of the Committee.

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

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medical Benefits. The Committee shall meet upon the joint call of the cochairs and may meet while the General Assembly is in regular session.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

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

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

"**§ 120-209.3. Additional powers.**

The Joint Legislative Oversight Committee on Primary Care, while in discharge of official duties, shall have access to any paper or document and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In

addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a joint committee of the General Assembly.

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

Whenever the DHHS is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters affecting the Department, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Primary Care."

SECTION 9. G.S. 120-208.1(a)(2)b. is repealed.

SECTION 10. G.S. 120-208.1(a)(1) reads as rewritten:

"**§ 120-208.1. Purpose and powers of Committee.**

(a) The Joint Legislative Oversight Committee on Health and Human Services shall examine, on a continuing basis, the systemwide issues affecting the development, budgeting, financing, administration, and delivery of health and human services, including issues relating to the governance, accountability, and quality of health and human services delivered to individuals and families in this State. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall do all of the following:

(1) Study the budgets, programs, and policies of each Division ~~within the Department of Health and Human Services,~~ listed in subdivision (2) of this subsection to determine ways in which the General Assembly may encourage improvement in the budgeting and delivery of health and human services provided to North Carolinians;"

SECTION 11. Notwithstanding any other provision of law, any reports by the Department of Health and Human Services or the Division of Medical Assistance related to Medicaid due during the 2014-2015 fiscal year shall be made to the Joint Legislative Oversight Committee on Primary Care.

SECTION 12. Consolidate LME/MCO Regions. – The Department of Health and Human Services shall manage the consolidation of LME/MCOs to no more than six, and no less than four, regional entities effective January 1, 2017.

To ensure a smooth transition and consolidation with minimal disruption to services, the DHHS shall designate the surviving entity for each region by October 1, 2015. DHHS shall take the following data into consideration in making the determination of surviving entity:

(1) Length of time LME/MCOs have operated the Medicaid 1915 (b)(c) Waiver;
(2) Performance under the Waiver;
(3) Number of counties served; and
(4) Prior history of successful mergers and consolidations with special consideration given for mergers and consolidations that have occurred since the LME/MCO implemented the Waiver.

The Department shall provide ongoing monitoring of the process to ensure that the deadlines are met.

SECTION 13. Sections 10 and 11 become effective September 1, 2015. Except as otherwise provided, this act is effective when it becomes law.