GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 838*
Health Care Committee Substitute Adopted 5/17/16

Short Title:	Medicaid Transformation Modifications.	(Public)
Sponsors:		
Referred to:		

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO REQUIRE FURTHER REPORTING FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RELATED TO TRANSFORMATION OF THE MEDICAID AND NC HEALTH CHOICE PROGRAMS AND TO MODIFY CERTAIN PROVISIONS OF THE MEDICAID TRANSFORMATION LEGISLATION.

The General Assembly of North Carolina enacts:

SECTION 1. No later than October 1, 2016, the Department of Health and Human Services shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division containing the following items:

(1) The status of the 1115 waiver submission to the Centers for Medicare and Medicaid Services (CMS), as well as any other submissions to CMS related to the transition of Medicaid and NC Health Choice from fee for service to capitation. The report shall specifically address the timeliness of the submission or submissions to CMS, responses received from CMS, and strategies necessary to ensure approval of a waiver for Medicaid transformation.

(2) A detailed Work Plan for the implementation of the transformation of Medicaid and NC Health Choice programs. The Work Plan shall provide sufficient detail to allow the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to monitor progress and identify challenges and impediments to the implementation of the transformation of Medicaid and NC Health Choice programs. The detailed Work Plan shall identify key milestones, tasks, and events necessary to the transition of the programs. For each milestone, task, and event, the Work Plan shall specify the expected completion dates and identify the individual who is assigned responsibility for accomplishing or ensuring the accomplishment of the milestone, task, or event.

(3) A sufficiently detailed description of any developments or changes during the planning process to enable the General Assembly to address any barriers to successful implementation of the Medicaid and NC Health Choice transformation.

SECTION 2.(a) Section 3 of S.L. 2015-245 reads as rewritten:

"**SECTION 3.** Time Line for Medicaid Transformation. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. –

a. The Division of Health Benefits of the Department of Health and Human Services (DHHS) is created pursuant to Section 10 of this act.

b. The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is created pursuant to Section 15 of this act to oversee the Medicaid and NC Health Choice programs.

c. ~~The Division of Health Benefits~~ DHHS shall begin development of the 1115 waiver and any other State Plan amendments and waiver amendments necessary to effectuate the Medicaid transformation required by this act.

(2) March 1, 2016. – ~~The DHHS, through the Division of Health Benefits,~~ DHHS shall report its plans and progress on Medicaid transformation, including recommended statutory changes, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, as required by subdivision (12) of Section 5 of this act.

(3) On or before June 1, 2016. – ~~The DHHS, through the Division of Health Benefits~~DHHS shall submit the waivers and State Plan amendments required by this act to the Centers for Medicare & Medicaid Services (CMS).

(4) Eighteen months after approval of all necessary waivers and State Plan amendments by CMS. – Capitated contracts shall begin and initial recipient enrollment shall be complete."

SECTION 2.(b) Section 4 of S.L. 2015-245 reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

(1) DHHS authority. – The Department of Health and Human Services (DHHS) shall have full authority to manage the State's Medicaid and NC Health Choice programs provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program, except the General Assembly shall determine eligibility categories and income thresholds. DHHS ~~through the Division of Health Benefits, created in Section 10 of this act,~~ shall be responsible for planning and implementing the Medicaid transformation required by this act.

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) ~~shall be excluded from the capitated contracts~~ until four years after the date capitated contracts begin.

b. ~~The capitated contracts required by this subdivision shall not cover dental~~Dental services.

c. Services provided through the Program of All-Inclusive Care for the Elderly (PACE).

d. Audiology, speech therapy, occupational therapy, physical therapy, nursing, and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or individual contracted with Local Education Agencies.

e. Services provided pursuant to a contract with Children's Developmental Services Agencies.

f. Services for Medicaid program applicants during the three-month retroactive eligibility period authorized by 42 U.S.C. § 1396a(a)(34). Services provided during a prospective, 12-month continuous enrollment period shall be covered by the capitated contracts.

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except ~~recipients~~ for the following categories:

a. Recipients who are dually eligible for Medicaid and Medicare. Recipients in the aged program aid category that are eligible for Medicare shall be considered recipients who are dually eligible for Medicaid and Medicare. The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act.

b. Qualified aliens subject to the 5-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611.

c, Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611.

d. Medically needy Medicaid recipients.

e. Members of federally-recognized tribes. Members of federally-recognized tribes shall have the option to enroll voluntarily in PHPs.

f. Presumptively eligible recipients, during the period of presumptive eligibility. Presumptively eligible recipients who submit a full Medicaid application and are determined eligible for the Medicaid program shall be covered by capitated contracts during the prospective, 12-month continuous enrollment period after they have been determined eligible.

(6) Number and nature of capitated PHP contracts. – The number and nature of the contracts required under subdivision (3) of this section shall be as follows:

a. Three contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid and NC Health Choice recipients statewide (statewide contracts).

b. Up to ~~10~~12 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to subdivision (2) of Section 5 of this act (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services required by subdivision (4) of this section. A PLE may bid for more than one regional contract, provided that the regions are contiguous.

c. Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State.

...."

SECTION 2.(c) Section 5 of S.L. 2015-245 reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of ~~DHHS, through the Division of Health Benefits,~~ DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. ~~DHHS, through the Division of Health Benefits,~~ DHHS shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by ~~DHHS, through the Division of Health Benefits.~~DHHS.

c. Until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by ~~DHHS, through the Division of Health Benefits.~~DHHS.

d. A requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS pursuant to subdivision (13) of this section, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers.

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

...

(11) Develop a Dual Eligibles Advisory Committee, which must include at least a reasonably representative sample of the populations receiving long-term services and supports covered by Medicaid. ~~The Division of Health Benefits,~~DHHS, upon the advice of the Dual Eligibles Advisory Committee, shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017.

...

(13) Designate Medicaid and NC Health Choice providers as essential providers if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice recipients within the region during the last three years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. DHHS shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

a. Federally qualified health centers.

b. Rural health centers.
c. Free clinics.
d. Local health departments.
e. State Veterans Homes."

SECTION 2.(d) Section 8 of S.L. 2015-245 reads as rewritten:

"**SECTION 8.** Innovations Center. – DHHS shall submit a program design and budget proposal no later than May 1, 2016, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice that will create a Medicaid and NC Health Choice Transformation Innovations Center ~~within the Division of Health Benefits~~ with the purpose of assisting Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. DHHS shall use the Oregon Health Authority's Transformation Center as a design model and shall consider at least the following features:

(1) Learning collaboratives, peer-to-peer networks.
(2) Clinical standards and supports.
(3) Innovator agents.
(4) Council of Clinical Innovators.
(5) Community and stakeholder engagement.
(6) Conferences and workshops.
(7) Technical assistance.
(8) Infrastructure support."

SECTION 2.(e) Section 9 of S.L. 2015-245 reads as rewritten:

"**SECTION 9.** Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this act, ~~the Department of Health and Human Services, through the Division of Health Benefits created in Section 10 of this act,~~DHHS 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. If such Medicaid-specific funding cannot be maintained as currently implemented, then ~~the Division of Health Benefits~~DHHS shall advise the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, created in Section 15 of this act, of any 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, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals."

SECTION 2.(f) Section 10 of S.L. 2015-245 reads as rewritten:

"**SECTION 10.** Creation of the Division of Health Benefits. – The Division of Health Benefits is established as a new division of the Department of Health and Human Services. ~~The Department of Health and Human Services, through the Division of Health Benefits, shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs.~~ The Division of Medical Assistance shall continue to operate the current Medicaid and NC Health Choice programs until the Division of Medical Assistance is eliminated. Upon the elimination of the Division of Medical Assistance, all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance of the Department of Health and Human Services are vested in the Division of Health Benefits. The Department of Health and Human Services shall remain the Medicaid single State ~~agency.~~ agency and shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the

transformed Medicaid and NC Health Choice programs. Prior to the effective date of G.S. 143B-216.85, the Secretary of DHHS may appoint a Director of the Division of Health Benefits."

SECTION 2.(g) G.S. 143B-216.80 reads as rewritten:

"**§ 143B-216.80. Division of Health Benefits – creation and organization.**

(a) There is hereby established the Division of Health Benefits of the Department of Health and Human Services. The Director shall be the head of the Division of Health Benefits. Upon the elimination of the Division of Medical Assistance, the Division of Health Benefits shall be vested with all functions, powers, duties, obligations, and services previously vested in the Division of Medical Assistance. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the powers and duties described in ~~G.S. 108A-54(e). The Director shall be the head of the Division of Health Benefits.~~ G.S. 108A-54(e) in addition to the powers and duties already vested in the Department.

(b) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:

(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.

(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but still may choose to utilize the State contract review and approval procedures for particular contracts."

SECTION 2.(h) G.S. 108A-54 reads as rewritten:

"**§ 108A-54. Authorization of Medical Assistance Program; administration.**

...

(e) The Department of Health and Human Services shall continue to administer and operate the Medicaid and NC Health Choice programs through the Division of Medical Assistance until the Division of Medical Assistance is eliminated at which time all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance are vested in the Division of Health Benefits. Prior to and following the exchange of powers and duties from the Division of Medical Assistance to the Division of Health Benefits, and in addition to the powers and duties already vested in the Secretary of the Department of Health and Human Services, the Secretary of the Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Employ clerical and professional staff of the Division of Health Benefits, including consultants and legal counsel, necessary to carry out the powers and duties of the division. In hiring staff for the Division of Health Benefits, the Secretary may offer employment contracts for a term and set compensation for the employees, which may include performance-based bonuses based on meeting budget or other targets.

(3) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(4) Establish and adjust all program components, except for eligibility categories and income thresholds, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.

(5) Adopt rules related to the Medicaid and NC Health Choice programs.

(6) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.

(7) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(8) Develop and present to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Office of State Budget and Management by January 1 of each year, beginning in 2017, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Department in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.

c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(9) Publish on its Web site and update on at least a monthly basis, at a minimum, the following information about the Medicaid and NC Health Choice programs:

a. Enrollment by program aid category by county.

b. Per member per month spending by category of service.

c. Spending and receipts by fund along with a detailed variance analysis.

d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(f) The General Assembly shall determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with the parameters set by the General Assembly.

~~(g) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:~~

~~(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).~~

~~(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).~~

~~(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.~~

~~(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but may still choose to utilize the State contract review and approval procedures for particular contracts.~~"

SECTION 2.(i) G.S. 143B-139.6C reads as rewritten:

"**§ 143B-139.6C. Cooling-off period for certain Department employees.**

(a) Ineligible Vendors. – The Secretary of the Department of Health and Human Services shall not contract for goods or services with a vendor that employs or contracts with a person who is a former employee of the Department and uses that person in the administration of a contract with the Department.

(b) Vendor Certification. – The Secretary shall require each vendor submitting a bid or contract to certify that the vendor will not use a former employee of the Department in the administration of a contract with the Department in violation of the provisions of subsection (a) of this section.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. – As used in this section, the following terms mean:

(1) Administration of a contract. – ~~Oversight~~The former employee's duties and responsibilities for the vendor include oversight of the performance of a contract, or authority to make decisions regarding a contract, including interpretation of a contract, ~~or participation in the~~ development of specifications or terms of a ~~contract or in the preparation~~ contract, or award of a contract.

(2) Former employee of the Department. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Department of Health and Human~~ Services, and in the six months immediately preceding termination of State employment, participated personally in either the award or management of a Department contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor.~~ Services and personally participated in any of the following:

a. The award of a contract to the vendor.

b. An audit, decision, investigation, or other action affecting the vendor.

c. Regulatory or licensing decisions that applied to the vendor."

SECTION 3. This act is effective when it becomes law.