HOUSE BILL 1181:
North Carolina Medicaid Modernization

2013-2014 General Assembly

Committee:	Rules and Operations of the Senate	**Date:**	July 16, 2014
Introduced by:	Reps. Dollar, Burr, Avila, Lambeth	**Prepared by:**	Ryan Blackledge Staff Attorney
Analysis of:	PCS to Third Edition H1181-CSME-25		

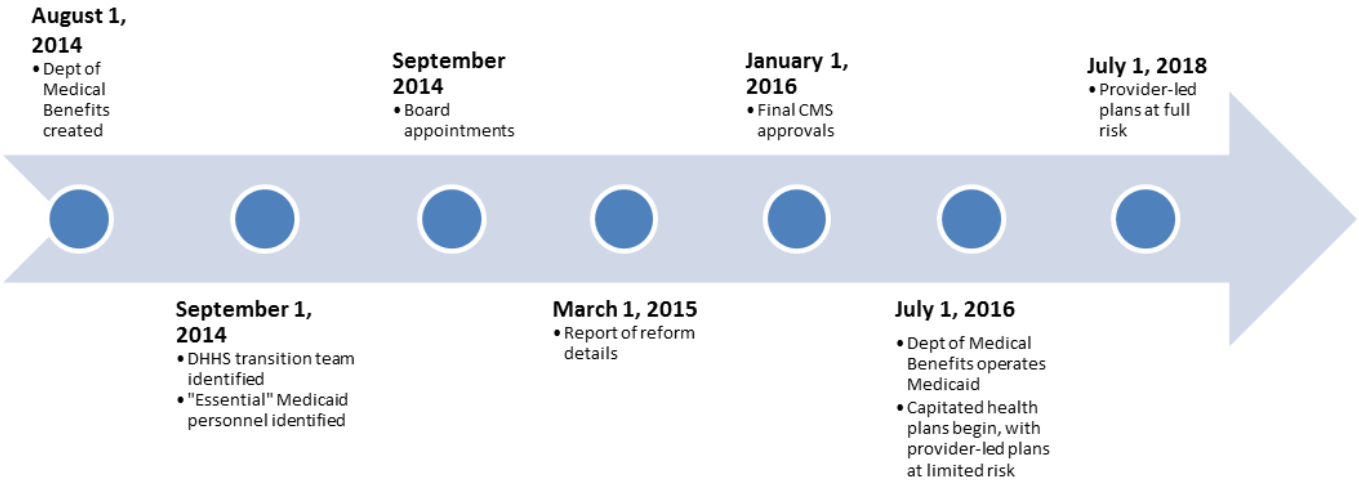
SUMMARY: ***The PCS to the Third Edition of HB 1181 directs a reform of the Medicaid program using provider-led and non-provider-led capitated health plans to take on all risks, other than enrollment numbers and enrollment mix. A new Department of Medical Benefits would be in charge of developing a detailed plan for the transformation of the Medicaid program as well as implementing the plan.***

The First Edition was an agency bill authorizing the implementation of the Governor's Medicaid reform proposal. The Third Edition, which passed the House, directed the Department of Health and Human Services to transition the Medicaid program to use provider-led capitated health plans.

BILL ANALYSIS: **Section 1** of the bill establishes the intent and goals of transforming the existing fee-for-services Medicaid program, with the primary goal of providing budget predictability.

Section 2 provides the principal building blocks of the reform: (i) a new Department of Medicaid, (ii) provider-led and non-provider-led capitated health plans, (iii) competition between health plan options, (iv) regional health plans, (v) risk-adjusted rates, (vi) participant choice, (vii) incentives for enrollees to be personally accountable for their health, (viii) mechanisms to help enrollees find ways to reduce their reliance on Medicaid, and (ix) strong performance metrics to hold providers accountable for quality.

Section 3 provides the following timeline for reform:



Section 4 requires that the Department of Medical Benefits develop a detailed Medicaid reform plan, to be reported to a new Joint Legislative Oversight Committee on Medical Benefits by March 1, 2015, as required by **Section 5** of the PCS. **Section 6** provides that semiannual reporting of the reform process would continue throughout the reform process until two years after provider-led plans are full risk.

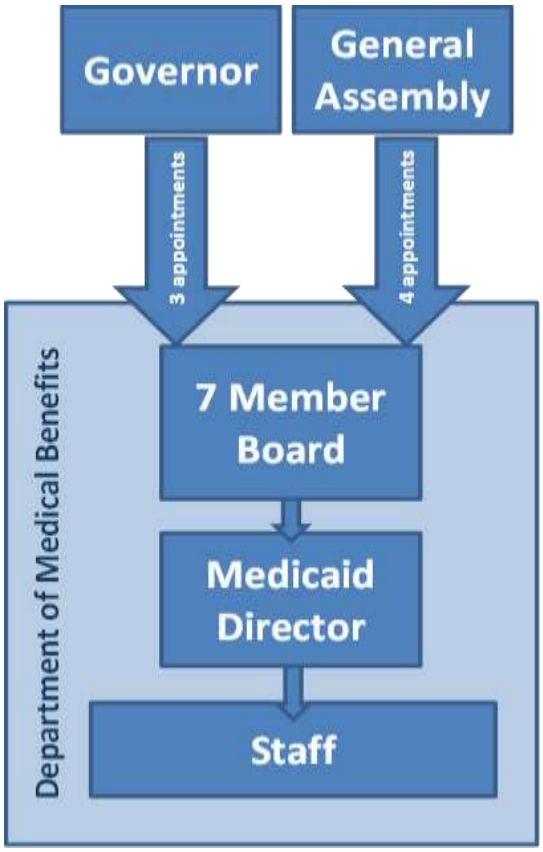
Section 7 encourages the Department of Medical Benefits to, if possible in the reform process, maintain existing funding levels for Medicaid that are generated through provider assessments.

Section 8 defines the role of the Department of Health and Human Services (DHHS) in Medicaid reform to include the following:

1. Clearly define responsibilities of DHHS and the new Department of Medical Benefits.
2. Submit SPAs as requested by the new Department.
3. Establish a Medicaid stabilization team within DHHS to coordinate the transition process.
4. Identify "essential positions" throughout DHHS without which the Medicaid program cannot operate. Employees in such positions will receive salary incentives to continue to work on the Medicaid program.
5. Ensure that all Medicaid-related contracts include appropriate cancellation clauses.

Section 9 states the commitment of the General Assembly to allow the time and to provide the money necessary for reform, to allow the Board to manage the Medicaid and NC Health Choice programs, and to support a new budgeting process that calls for advanced forecasting of expected program growth and costs.

Section 10 creates the Department of Medical Benefits by creating a new Article 14 in Chapter 143 of the General Statutes. The new Department would vary from other State departments in that it would not be managed by an appointed secretary or constitutional officer, but a seven-member board of experts appointed by the Governor and the General Assembly. The Governor would choose the board chair, who would serve on the Governor's cabinet. The Board would employ the Medicaid Director, who would be responsible for the day-to-day management of the Medicaid and NC Health Choice programs. The members of the Board must have expertise in areas such as health insurance and health care, and Medicaid providers cannot serve on the board. The Secretary of the Department of Health and Human Services would also serve on the board as an *ex officio*, non-voting member.



The Board would have broad authority to operate the Medicaid and NC Health Choice programs, including duties to make mid-year corrections to stay within budget and submit to the General Assembly a five-year forecast of expected changes in enrollment numbers and enrollment mix.

Certain State laws that apply to other State departments would not apply to the Department of Medical Benefits. Employees of the Department would be exempt from several provisions of the State Personnel Act and those personnel contracts would not be subject to review by the Office of State Human Resources. The Department could also retain legal counsel other than the Attorney General. The Board would have additional reasons to move into a closed executive session, such as when discussing rates and forecasts. Materials related to rate preparation, audits and investigations, the annual forecast, and other reports for the General Assembly would not become public record until the relevant document is published.

Section 11 provides an initial Board compensation of $8000 per month, half of which would be paid with federal Medicaid funds.

Section 12 creates a new Joint Legislative Oversight Committee on Medical Benefits to oversee the Medicaid and NC Health Choice programs, including the transition of the programs to the new Department of Medical Benefits and any Medicaid matters that previously would have been addressed by the Joint Legislative Oversight Committee on Health and Human Services.

COMPARISON OF HOUSE'S THIRD EDITION TO SENATE PCS ON MAJOR POINTS:

	House's Third Edition	Senate PCS
Basic Goal	"…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."	Same
Type of Plans	Full-risk capitated health plans	Same
Operators of Plans	Providers	Providers and non-providers
Medicaid Enrollees Covered	"…majority of the Medicaid population…"	"…all Medicaid recipients…"
Risk Implementation for Plans	Full risk by 2020	Full risk in 2016 for non-provider-led plans; 2018 for provider-led plans
Department to Implement Reform	Existing Department of Health and Human Services	New Department of Medical Benefits
Additional Plan Details	Developed and reported back to General Assembly	Same

EFFECTIVE DATES: The Department of Medicaid would be created August 1, 2014, and Sections 10, 11, and 12 become effective on that date. The remainder of the PCS would be effective when it becomes law, but includes various reporting dates.

BACKGROUND: Medicaid is an entitlement program that provides medical assistance to needy North Carolinians. Approximately two-thirds of the funding for services comes from the federal government. Except for behavioral health services, the program primarily reimburses providers on a fee-for-service basis. Section 12H.1 of S.L. 2013-360 called upon the Department of Health and Human Services (DHHS) to develop a Medicaid reform plan. DHHS proposed a plan in which providers would organize accountable care organizations (ACOs) that would take on certain amounts of risk and share in savings. The First Edition of HB 1181 was an agency bill that would have allowed DHHS to implement its plan. The Third Edition of HB 1181, which passed the House, directed the DHHS to transform the existing fee-for-service payment structure into provider-led capitated health plans to take on all risks, other than enrollment numbers and enrollment mix.