House Proposal: H 372 (Edition 3)	*NCMS Position*	*Senate Proposal: H 97 (June 15 version)*
Governance		
Section 2: (5) Provider-led entity. – Any of the following: a. A provider. b. An entity with the primary purpose of owning or operating one or more providers. c. A business entity in which providers hold a controlling ownership interest. (P. 1) Section 3: (10) A majority of each provider-led entity's governing board shall be comprised of physicians who treat Medicaid patients including those who provide clinical services to Medicaid patients. (P. 2) Not sufficient – Needs to reflect a balance of employed and independent physician perspectives reflective of the PLE community	NCMS supports a requirement that a majority of the board of directors of new risk-bearing entities shall be physicians representing the prevailing practice settings in the network and who provide clinical services to Medicaid patients.	PLE governing board must have a "provider" majority: Section 12H.24.(b): "The majority of the members of a PLE's governing board shall be composed of providers as defined in G.S. 108C-2 or entities composed of providers." (P. 180) No stipulations for MCO governance. "Provider" should be replaced with "physician" along with a requirement to be reflective of PLE community
Data		
Section 7: HHS directed to… (5) Adopt and implement requirements for the contracts entered into under Section 6 of this act concerning Health Information Technology, robust data analytics, quality of care, and care-quality improvement. (P. 4) Not sufficient – too vague	NCMS supports data provisions requiring use of an HIE, and ample access to robust clinical & claims data. NCMS supports integration of the CSRS, registries and any other items focused on increased transparency.	Section 12H.24.(d): Requires all Medicaid providers to use the NC HIE by 7/1/17, all other providers by 1/1/18. Allows for "reasonable participation fees" to be charged to providers for connectivity/funding. (P. 181) (Also Article 29B, P. 118-119) Support – robust HIE provision

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Timeline		
Requires 90% managed care within 5 years of enactment of law. Section 4: (1) Within 12 months of this act becoming law, the Department shall develop, with meaningful stakeholder engagement, and submit to CMS a request for an 1115 Medicaid demonstration waiver to implement the components of this act. (2) Within 24 months of this act becoming law and with waiver approvals from CMS, the Department will issue an RFP for provider-led entities to bid on contracts required under this act. (3) Within five years of the date this act becomes law, ninety percent (90%) of Medicaid recipients shall be enrolled in full-risk, capitated health plans for all services other than the services contracted for through the local management entities/managed care organizations (LME/MCOs), dental services, and pharmaceutical products. However, prior to reaching the coverage required under this subdivision, the Department may accept a full-risk, capitated health plan as a pilot that begins within three years of enactment of this act. (4) Within six years of the date this act becomes law, each provider-led entity under contract with the Department must meet the risk, cost, performance, and quality goals required by this act and as contained in the contract with the Department. (P. 2-3)	NCMS supports a sufficient timeline (minimum of 5 years) for transition to full capitation, based on approval of CMS waiver.	Section 12H.24.(c): Requires all entities to be in fully capitated contracts with the state by 8/1/17. Requires first open enrollment period to begin 4/1/17. (P. 181) Timeline is not realistic, oppose

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Timeline should be built upon CMS approval of the waiver, not passage of law		
Triple Aim		
Triple aim vaguely referenced in intent and goals section. Section 1: It is the intent of the General Assembly to transform the State's current Medicaid program to a program that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid program shall be designed to achieve the following goals: (1) Ensure budget predictability through shared risk and accountability. (2) Ensure balanced quality, patient satisfaction, and financial measures. (3) Ensure efficient and cost-effective administrative systems and structures. (4) Ensure a sustainable delivery system. (5) Improve health outcomes for the State's Medicaid population. (P. 1) Not sufficient	Triple Aim must be enforced in all contracts with the state, and in all provider contracts with PLEs/MCOs. The Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, called the "Triple Aim": • Improving the patient experience of care (including quality and satisfaction); • Improving the health of populations; and • Reducing the per capita cost of health care.	Triple aim explicitly expressed in intent and goals section, in contracting requirements with MCOs and PLEs. Section 12H.24.(a): "The new Medicaid program shall be designed to achieve the following goals: (1) Ensure budget predictability through shared risk and accountability. (2) Ensure balanced quality, patient satisfaction and financial measures. (3) Ensure efficient and cost-effective administrative systems and structures. (4) Ensure a sustainable delivery system." (P. 180) Section 12H.24.(d): "All bidders ensure that their contracts with providers include value-based payment systems that support the achievement of overall performance, quality and outcome measures." (P. 181) Support the incorporation of quality measures, patient satisfaction requirements. Would prefer to see stronger requirements, however new CMS regulations, if finalized, would address this in any managed care contract with Medicaid

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Carve-outs		
Section 4: LME/MCO, dual eligible, dental services, pharmaceutical services carved out. (P. 2-3) Do not support carve outs	NCMS supports full integration of all services over a transitional period of time sufficient to make such changes.	Section 12H.24.(d): Dual eligible w/ copay payment only carved out. (P. 181) Do not support carve outs
Patient & Provider Protections		
Department to ensure patient access. Section 7: The Department is directed to… Ensure recipients have appropriate access to primary care and specialty care services and shall develop a rate floor for this purpose. (P. 4) Not sufficient	NCMS supports the inclusion of sufficient managed care protections for physicians (rates, access/network adequacy, enrollment requirements, etc.). Refer also to "items not included" section for a full list of protections supported by the NCMS.	Section 12H.24.(d): "All bidders establish appropriate networks or providers to deliver services." (P. 181) Not sufficient Section 12H.25.(e): Increases primary care and OBGYN payment rates to 100% of Medicare. (P. 197) Support with change to make applicable to all primary care and not just those that attested under the ACA
Financial Solvency Requirements		
Section 6: PLEs must meet financial solvency requirements developed by the Department of Insurance that are equivalent to the solvency requirements for health maintenance organizations in G.S. 58-67-110. (P. 3) Support	NCMS supports regulatory oversight of PLEs, adapted as necessary for provider-led entities.	Section 12H.24.(d)(2)c: All Dept. of Insurance solvency requirements apply. (P. 181) Oppose total Ch. 58 applicability for PLEs. NC insurance laws should be tailored to regulate PLEs through specific provisions while maintaining appropriate patient and provider protection statutes.

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Clinical Quality Measurement & Oversight		
Section 8: Quality Assurance Advisory Committee – The Secretary shall convene an advisory committee consisting of experts in the areas of Medicaid, actuarial science, health economics, health benefits, and administration of health law and policy. At least one shall be a member of the North Carolina State Health Coordinating Council. The Committee shall advise the Department on the development and submission of requests for all federal waivers that are necessary to implement this act and to support the development and approval of the performance goals that will serve as the basis of the pay-for-performance system. The committee shall terminate five years from the date of enactment of this act. (P. 4) Physician involvement must be more prevalent in the governing as well as the clinical quality measures establishment. Lack of requirements regarding the governing board to address recommendations from the Quality Care Committee is problematic.	NCMS supports robust clinical quality measurement and oversight, with meaningful physician feedback and participation in such oversight	Section 12H.24.(d): Defined measures and goals for risk adjusted health outcomes, quality of care, patient satisfaction and cost. To be monitored and measured continually and reported at set intervals as determined by the Health Benefits Authority. The Authority may use organizations such as NCQA, PCPI, HEDIS and others as necessary to develop effective measures for outcomes and quality. (P. 181) Support for this must include a more detailed requirement to incorporate quality into the governance of PLEs and MCOs. NCMS would like to see additional requirements regarding physician input and participation as well as clarity on the establishment of quality standards by the proposed Authority.
Regions		
Section 3: No requirement, however PLEs must be present in all 100 counties. (P. 2) Neutral	NCMS opposes state mandated regions	Section 12H.24.(b): Six regions to be established. (P. 180) Oppose

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DHHS Role in Reform		
NC DHHS to submit waiver to CMS and manage contracts with PLEs and the state. PLEs responsible for all administrative functions for the PLE (claims processing, appeals etc.). Section 7: The General Assembly delegates full authority to the Department of Health and Human Services to take all actions necessary to implement the Medicaid transformation described in this act. The Department shall administer and manage the program within the budget enacted by the General Assembly provided that the total expenditures, net of agency receipts, for the Medicaid program do not exceed the enacted budget. (P. 4) Neutral	NCMS has no position on NC DHHS' role in reform. However, we oppose an independent board of corporate experts, as previously passed in the Affordable Care Act, jointly appointed by the Governor and the NC General Assembly without oversight and accountability to an elected official or body.	Article 14: No role for NC DHHS. Establishes a "Health Benefits Authority" to administer the Medicaid and Health Choice programs. (P. 185-192) Oppose Article 23B: Also establishes a Joint Legislative Oversight Committee for the new Health Benefits Authority. (P. 192) Support
Waiver		
Section 4: 1115 Medicaid Demonstration waiver while also maintaining existing 1915 (b)/(c) Waiver. (P. 2) Support provided that transparency and accounting of supplemental payments are included in the formulation of any capitated system	NCMS supports use of an 1115 waiver for Medicaid reform provided there is a transparent and appropriate accounting of all supplemental revenue streams.	Not stated.

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Assignment of Patients		
Section 3: The Department implements a process for recipient assignment to provider-led entities. Assignment shall be based on the recipient's selection of a provider-led entity, or if the recipient fails to choose a provider-led entity during initial enrollment, the Department shall develop a process for auto-assignment to a provider-led entity. The Department may limit the circumstances under which a Medicaid recipient may change provider-led entity, including creating an open enrollment period. (P. 2) Support	NCMS supports patient assignment by medical home or primary care physician.	Not included
Minimum Patient Coverage Requirements		
Section 6: PLEs must cover at least 30,000 patients. (P. 3) Neutral	NCMS supports PLE entities being capable of complying with reasonable patient coverage requirements (30-50,000?).	Not stated. Neutral
Medical Loss Ratio Requirements		
Section 3: PLEs must have a 90/10 Medical Loss Ratio. (P. 2) Support, with the inclusion of appropriate definitions	NCMS supports a 90/10 Medical Loss Ratio with appropriate definitions specifying inclusion of patient supports in the "medical" component of MLR.	Section 12H.24.(d): None specifically stated, but the state must "negotiate competitive medical loss ratios." (P. 182) NCMS calls for a Medical Loss Ratio with appropriate definitions included

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Requirements to Build on Existing Care Coordination Structures		
Allows for continuation of current care coordination efforts through transition. Support Section 3: Provider-led entities ensure appropriate access to care for Medicaid recipients in all 100 counties while building upon the existing enhanced primary care medical home model. (P. 2) Support	NCMS supports maintaining and building upon the current care coordination and networks through the transition period to maintain continuity of care and MOE on cost containment.	Section 12H.25.(a): Excludes current care coordination efforts and networks through the transition by eliminating all CCNC contracts effective Jan. 1 2016. (P. 197) Oppose
Other Issues		
Provision requires PLEs to remain 2% below national spending growth calculated by CMS. Section 3: Provider-led entity contracts result in controlling the State's cost growth 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 non-expansion states. (P. 2) Oppose	Other issues in House and Senate proposals	Section 12H.24.(d): All MCOs/PLEs must subcontract with LME/MCOs. (P. 178) Neutral Section 12H.24.(b): 3 entities must provide statewide coverage, there will be opportunities for PLEs, and up to 12 contracts between the Authority and individual PLEs for coverage of specified regions (regional contracts). (P. 180) Oppose. Must have a neutral framework for competition to occur. Allows but does not require a regional PLE. Section 12H.24.(g): DHHS will also establish a "Medicaid Stabilization Team" in

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		the interim while transitioning to fully capitated entities. (P. 183-185) Neutral

Issues Not Included in Either Proposals

NCMS supports the inclusion of the following in any Medicaid reform plan:

- Provider rates no less than existing FFS rates
- Prohibit exclusive contracting as a condition for participation and prohibit tying of provider network contracts to participation in networks supporting commercial products
- Public reporting of PLE performance
- Tort protections
- Maintain a statewide formulary
- Administrative simplification:
  - Single credentialing process
  - Single prior authorization process
- Extension of NCGS Ch. 58 protections including:
  - "Clean claim" standards requiring timely payments
  - Standards for out of network provider payments
  - Establishment of Prior Authorization policies defining standards for the timeliness and efficiency of PAs
  - Establishment of an "any willing provider" rule requiring PLEs to contract with any provider that is willing to meet the terms of the contract
  - Require use of NCQA standards for provider credentialing to reduce administrative burden imposed on providers
  - Require PLEs to notify providers, state of significant network changes
  - Financial penalties for violation of network and medical necessity standards
  - Requirement to support (financially and operationally) quality initiatives already in place
  - Extend NC's patient protection laws to Medicaid PLEs