North Carolina Medical Society
Leadership in Medicine

**HB 372, Medicaid Transformation: 5th Edition**

**Highlights**

-Both MCOs and PLEs may compete for business. There must be at least 3 and no more than 5 enrollment choices for Medicaid patients in each region established. At least 3 MCOs/PLEs must provide statewide coverage.

-A new Department of Medicaid is created as an executive department to oversee and operate the Medicaid and NC Health Choice programs.

-There must be at least 5 and no more than 8 regions. Every county in the state must be assigned to a region (regions to be determined by the new Department of Medicaid).

-12 months after CMS approval of all necessary waivers and State Plan Amendments, capitated full-risk contracts begin.

-Components of initial Requests for Proposals for MCOs/PLEs and certain contract requirements:

- Full risk capitation for all Medicaid health care items and services and coverage for all program categories except the dual eligible categories.
- All bidders must meet standards and metrics for risk, outcomes and quality.
- All bidders must establish "appropriate networks" or providers to deliver services.
- All bidders must subcontract with existing LME/MCOs for behavioral health services through the end date of the first contract entered into.
- All bidders must agree not to limit providers' ability to contract with other commercial insurers and PLEs.
- All bidders must ensure that their contracts with providers include value-based payment systems that support the achievement of overall performance, quality and outcomes measures.
- Rates must be based on CMS actuarial soundness and industry standards as well as risk-adjusted rate ranges using claims data from FY 2014-2015.
- Each contract must negotiate full risk capitated rates, including a portion that is at risk for achievement of quality and outcomes measures.
- A rate floor for primary care and specialty care services will be set by the new Department of Medicaid to ensure access to services.

-A Medicaid Reserve Account is established as a nonreverting reserve in the General Fund. The account will provide for unexpected budgetary shortfalls within the Medicaid and NC Health Choice programs and will operate with a minimum 5% of a given fiscal year's General Fund appropriations for capitation payments and a maximum of 12%.

-The MCO/PLE must keep the cost growth for its enrollees at least 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.

-The Department of Insurance will establish solvency requirements for MCOs and PLEs.

-A Joint Legislative Oversight Committee on Medicaid is established.

-The General Assembly will continue to set eligibility categories and income thresholds for the Medicaid program.

-A state-controlled Health Information Exchange is established. $8M in recurring funds for 2015-2016 and 2016-2017 fiscal years are appropriated to the Department of Health and Human Services towards implementation of a statewide HIE. All providers and entities receiving state funds must connect to the HIE network and submit individual patient demographic and clinical data on services paid for with state funds. An HIE Authority is established to oversee and administer the HIE Network, along with an HIE Advisory Board.

-Effective May 1, 2016 the current Medicaid and Health Choice primary care case management program is discontinued.

-Effective May 1, 2016 and until the implementation of the new capitated system, the rates paid to primary care physicians shall be 100% of the Medicare rate, including OB/GYN physicians.