

Key Details in Compromise Medicaid Reform Bill (HB372)

On September 17, the legislature released their compromise version of Medicaid reform [legislation](#). The conference report for HB 372, Medicaid Transformation and Reorganization, takes a hybrid approach to reforming the state's current fee-for-service Medicaid program by allowing both commercial plans and Provider-Led Entities (PLE) to compete for Medicaid business in the state under a fully capitated system. Both the House and Senate have now passed this compromise legislation into law and the medical community now must look forward to the long road of implementation that lies ahead.

The North Carolina Medical Society (NCMS) has advocated since the beginning of the state's Medicaid reform debate nearly three years ago for physicians to lead reform efforts, rather than relying on the standard corporate managed care solution so many other states have used to address budgeting issues within the program. With the introduction of managed care into the state, we must now focus our efforts on using this transition time to implement value-based, patient-centered care models for Medicaid patients.

Here are some of the key details of the compromise legislation:

Hybrid approach

The General Assembly states their intent to transform North Carolina's current Medicaid and NC Health Choice programs to programs that provide additional budget predictability for taxpayers while ensuring quality care for Medicaid patients. The following goals are identified in the legislation: ensure budget predictability through shared risk and accountability; ensure balanced quality, patient satisfaction and financial measures; ensure efficient and cost-effective administrative systems and structures; ensure a sustainable delivery system. (Part I, Section 1)

- The legislation calls for a hybrid approach, allowing for both Provider-Led Entities and Commercial Plans (managed care organizations) to compete in six regions to be specified by the North Carolina Department of Health and Human Services (NCDHHS). All participants must operate a capitated contract for the delivery of 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 stated (LME/MCOs are excluded from capitated contracts until four years after the date capitated contracts begin). (Part I, Section 4)
- To qualify as a PLE, the PLE must be owned by one or more Medicaid and NC Health Choice health care providers. The majority of the entity's governing body must be composed of physicians, physician assistants, nurse practitioners or psychologists. Each PLE also will be

required to hold a new Pre-Paid Health Plan (PHP) license issued by the NC Department of Insurance. (Part I, Section 4)

- There must be three statewide contracts, and up to 10 regional contracts total. Each regional contract must provide coverage throughout the entire region and PLEs may bid for more than one regional contract if the regions are contiguous. Initial capitated contracts will be awarded on staggered terms of three to five years in duration. (Part I, Section 4)

Triple Aim oriented contracts

- The legislation stipulates capitated contracts must be built on defined measures and goals for risk adjusted health outcomes, quality of care, patient satisfaction, access and cost to achieve the Triple Aim. Each component will also be subject to specific accountability measures, including potential penalties. The Division of Health Benefits may use organizations such as the National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI) or any others necessary to develop outcome and quality measures for the program. (Part I, Section 4)

Timeline for implementation

- Implementation of fully capitated prepaid health plans (both commercial plans and PLEs) shall begin 18 months after CMS waiver approval. The amount of time CMS takes to review these types of State Medicaid Plan waivers varies, but it is anticipated this process could take up to 18 months (Part I, Section 3)

Health Information Exchange Network

- The legislation requires the use of a statewide and state-controlled Health Information Exchange (HIE) Network. The HIE will be housed in the NCDHHS as prescribed by the budget, HB 97. All Pre-Paid Health Plans (MCOs and PLEs) as well as Medicaid providers must submit data through the Health Information Exchange Network. (Part I, Section 5)

Community Care of North Carolina (CCNC)

- Current CCNC contracts and programs are preserved throughout the transition period. By July 1, 2016 DHHS will renegotiate its current contract with NCCCN to reduce per member per month payments to NCCCN for administration by 15 percent. When capitated Pre-Paid Health Plan contracts begin, contracts with NCCCN existing on that date will terminate. (Part I, Section 7)

Patient and provider protections

- Chapter 58 commercial insurance requirements will apply to all participating Prepaid Health Plans (PHP). (Part I, Section 4)
- Appropriate rate floors must be established for in-network primary care physicians, specialist physicians and pharmacy dispensing fees as recommended by NCDHHS. (Part I, Section 5)
- All participants must develop and maintain provider networks that meet access to care requirements for their enrollees and may not exclude providers from their networks except for quality reasons or refusal to accept network rates. (Part I, Section 5)

- Medical loss ratio minimum of 88 percent is established until final federal regulations are promulgated governing these requirements. (Part I, Section 5)

New Division of Health Benefits

- A new Division of Health Benefits to be established will replace the current Division of Medical Assistance within NCDHHS to fully manage, oversee and enforce capitated prepaid health plan contracts (both PLEs and commercial plans). (Part II, Section 11-15)

Excluded populations (carve-outs)

- Excluded populations are LME/MCOs for a four-year period following capitation, as well as patients who are dually eligible for Medicare and Medicaid. (Part I, Section 4)

Drugs

- Spending for prescribed drugs, net of rebates, must ensure the state realizes a net savings for the spending on prescription drugs. All participants will be required to use the same statewide drug formulary to be established by NCDHHS. (Part I, Section 4)

Innovations Center

- The legislation directs the NCDHHS to submit a program design and budget proposal to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice that will create a Transformation Innovations Center within the Division of Health Benefits to assist providers in achieving the goals of the Triple Aim. The Center will be designed to support providers through technical assistance, learning collaborative and other models that foster peer-to-peer sharing of best practices. (Part I, Section 8)

Joint Legislative Oversight Committee on Medicaid

- Establishes a new Joint Legislative Oversight Committee on Medicaid to examine budgeting, financing, administrative and operational issues related to the Medicaid and NC Health Choice programs administered by NCDHHS. This is expected to be established and to begin meeting before the end of the year. (Part II, Section 16)

Role of the Department of Insurance

- The Department of Insurance will license Pre-Paid Health Plans (MCOs and PLEs) based on solvency requirements established by the DOI in consultation with the Director of the Division of Health Benefits. These entities will also recommend licensing procedures including an annual review by the Commissioner and reporting of changes in licensure to the Division of Health Benefits.