

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

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HOUSE BILL 1181

Short Title: Partnership for a Healthy North Carolina 2014-AB (Public)

Sponsors: Representatives Dollar, Burr, Avila, and Lambeth (Primary Sponsors).

For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.

Referred to: Health and Human Services, if favorable, Appropriations.

May 22, 2014

A BILL TO BE ENTITLED

1
2 AN ACT TO FURTHER REFORM THE NORTH CAROLINA MEDICAID DELIVERY
3 SYSTEM, TO IMPLEMENT A COORDINATED CARE MODEL OF DELIVERY TO
4 BRING LONG-TERM PREDICTABILITY, SUSTAINABILITY, AND EFFICIENCY TO
5 THE STATE'S MEDICAID PROGRAM, AND TO APPROPRIATE FUNDS.

6 Whereas, North Carolina's Medicaid program is the nation's tenth largest. Of the
7 State's nearly 10 million residents, approximately 2.3 million received Medicaid coverage for at
8 least part of 2013; and

9 Whereas, the current health care delivery and payment system often fails to provide
10 high-quality, cost-effective health care to the most vulnerable patients residing in North
11 Carolina, many of whom have limited access to coordinated and primary care services and,
12 therefore, tend to delay care, underutilize preventive care, seek care in hospital emergency
13 departments, and be admitted to hospitals for preventable problems; and

14 Whereas, North Carolina today has the opportunity to capture more value for its
15 spending on Medicaid. Instead of paying for medical services on a purely fee-for-service basis
16 that merely rewards volume and intensity of services, the State can redesign payment and care
17 coordination models to reward advances in quality and patients' health outcomes; and

18 Whereas, by altering the current payment model to one that holds providers
19 accountable for meeting budget targets and quality goals, North Carolina can ensure that
20 Medicaid beneficiaries receive care that is more prevention-focused, is integrated across
21 physical, behavioral, and long-term care domains, and is well-coordinated as patients move
22 across settings of care; and

23 Whereas, the Department of Health and Human Services has developed a detailed
24 plan to create a predictable and sustainable Medicaid program for North Carolina taxpayers;
25 increase administrative ease and efficiency for providers; and provide care for the whole person
26 by uniting physical and behavioral health care, significantly reforming the current Medicaid
27 program delivery system; Now, therefore,

28 The General Assembly of North Carolina enacts:

29 **SECTION 1.** This act shall be known as the "Partnership for a Healthy North
30 Carolina Act of 2014."

31 **SECTION 2.** Accountable Care Organizations. – (a) The General Statutes are
32 amended by adding a new Chapter to read:

"Chapter 108E.

"Medicaid Accountable Care Organizations.

"Article 1.



"General Provisions."§ 108E-1. Definitions.

The following definitions apply in this Chapter, unless the context clearly requires otherwise:

- (1) Accountable Care Organization or ACO. – An entity created to include more than one health care provider that is intended to be associated with a defined population of patients and is accountable for the quality and cost of care that is delivered to a defined population of patients and through which health care providers share in savings created by (i) improving the quality of care to the defined population of patients and (ii) reducing the growth of the cost of care delivered to the defined population.
- (2) Department. – The North Carolina Department of Health and Human Services.
- (3) Division. – The Division of Medical Assistance of the North Carolina Department of Health and Human Services.
- (4) Health care provider. – Any person who is licensed to practice as a physician or a physician assistant, nurse practitioner, or clinical nurse specialist under Chapter 90 of the General Statutes.
- (5) Hospital. – Any facility which has an organized medical staff and which is designed, used, and operated to provide health, diagnostic, and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Article 1 of Chapter 90 of the General Statutes to two or more persons over a period in excess of 24 hours.
- (6) Local Management Entity Managed Care Organization or LME/MCO. – Consistent with G.S. 122C-3(20c), a local management entity that is under contract with the Department to manage North Carolina's Medicaid and State-funded mental health, developmental disabilities, and substance abuse services (MHDDSAS) pursuant to the combined Medicaid Waiver program authorized under section 1915(b) and section 1915(c) of the Social Security Act. In the event that one or more of the LME/MCOs should merge or otherwise reorganize, the meaning of the term for purposes of this Chapter shall be the successor entity.
- (7) Medicaid. – The Medical Assistance program authorized under G.S. 108A-54 and as set forth in the North Carolina State Plan of Medical Assistance. For purposes of this Chapter, the term "Medicaid" shall also include the Health Insurance Program for Children authorized by G.S. 108A-70.25 (known as "NC Health Choice") and as set forth in the North Carolina State Plan of the Health Insurance Program for Children.
- (8) Medicaid ACO. – An ACO qualified to participate in the Department's Medicaid ACO Program.
- (9) Medicaid ACO Program. – Program administered by the Department whereby Medicaid ACOs are assigned an annual budget based on a trended, risk-adjusted health cost history of assigned beneficiaries and claims of assigned beneficiaries are debited against the budget. ACOs share in savings or losses realized, with the outcome tied to ACOs' performance on predetermined quality measures.
- (10) Primary Care Physician or PCP. – A health care provider in family practice, internal medicine, obstetrics/gynecology, or pediatrics who is the patient's first contact for health care in an ambulatory setting and who coordinates all

1 of the beneficiary's health care services and who initiates and monitors
2 referrals for specialty care.

3 **"§ 108E-2. Establishment of Medicaid ACO Program.**

4 The Department of Health and Human Services shall establish a Medicaid ACO Program to
5 begin reforming North Carolina's current fee-for-service system in a manner modeled by the
6 federal Medicare Shared Savings Program, 42 C.F.R. Part 425, with adaptations necessary to
7 reflect the needs and strengths of North Carolina's Medicaid program and its health care
8 community. It is the intent of the General Assembly that all eligible Medicaid beneficiaries will
9 eventually receive services through a Medicaid ACO.

10 **"§ 108E-3. Powers and duties of the Secretary.**

11 The Secretary of Health and Human Services shall do all of the following:

- 12 (1) Oversee development and implementation of the Medicaid ACO Program.
- 13 (2) Enforce the provisions of this Chapter and the rules adopted pursuant to this
14 Chapter.
- 15 (3) Establish a process and criteria for the submission, review, and approval or
16 disapproval of Medicaid ACO Program applications.
- 17 (4) Adopt rules specifying the content and format of Medicaid ACO Program
18 applications.
- 19 (5) Review Medicaid ACO Program applications and, upon approval of an
20 application, certify the submitting entity to participate in the Medicaid ACO
21 Program.
- 22 (6) Establish comprehensive, cohesive oversight and monitoring procedures and
23 processes to ensure continuous compliance by Medicaid ACOs with State
24 and federal policies, laws, and standards.
- 25 (7) Monitor Medicaid ACOs to ensure that they are collectively meeting
26 Program performance goals.
- 27 (8) Adopt rules governing the assignment of beneficiaries into Medicaid ACOs.
- 28 (9) Adopt rules establishing procedures for waiver of rules adopted by the
29 Secretary under this Chapter.
- 30 (10) Administer and enforce rules that are conditions of participation for federal
31 and State financial aid.
- 32 (11) Develop a methodology for setting ACO-specific spending benchmarks
33 under the Medicaid ACO Program and calculating cost savings or losses and
34 determining amounts owed to or by ACOs.
- 35 (12) Enforce the protection of the rights of Medicaid enrollees served by
36 Medicaid ACOs.
- 37 (13) Implement standard forms, contracts, processes, and procedures to be used
38 in the Medicaid ACO Program.
- 39 (14) Adopt rules establishing a procedure to provide continued care coordination
40 upon a Medicaid ACO's dissolution or termination from the Medicaid ACO
41 Program.
- 42 (15) Adopt rules for public reporting by the Medicaid ACO of quality measures
43 and organizational information.
- 44 (16) Adopt such rules and regulations governing the ongoing oversight and
45 monitoring of the quality of care delivered to Medicaid beneficiaries served
46 by the Medicaid ACOs and such other requirements as the Secretary deems
47 necessary to carry out the provisions of this Chapter.

48 "Article 2.

49 "Minimum Requirements for Medicaid ACO Program Participation.

50 **"§ 108E-4. Applications for certification as a Medicaid ACO.**

1 (a) The Department shall develop a process to certify applicants for participation in the
2 Medicaid ACO Program and shall ensure any approved applicant meets the minimum
3 requirements specified in this Article.

4 (b) The Department shall deny certification to any ACO applicant that the Department
5 determines does not adequately describe how it will establish and maintain an ongoing process
6 for quality assurance and quality improvement or does not meet the requirements of this
7 Chapter. Applicants denied certification shall be afforded the opportunity to reapply for
8 consideration to participate in the following ACO contract period.

9 (c) The application shall require the applicant to document how it (i) plans to promote
10 evidence-based medicine, promote beneficiary engagement, report internally on quality and
11 cost metrics, and ensure coordination of care for beneficiaries assigned to it and (ii) will
12 emphasize patient-centeredness and contribute to whole-person care.

13 (d) The application shall require the applicant to commit to become accountable for the
14 quality, cost, and overall care of the beneficiaries assigned to it.

15 (e) The application shall require the applicant to demonstrate the capability of receiving
16 and distributing shared savings; repaying shared losses; establishing, reporting, and ensuring
17 that all participating providers comply with program requirements, including quality
18 performance standards; and performing other requisite ACO functions as set forth in statute and
19 regulation.

20 (f) The application shall require the applicant to demonstrate how it intends to
21 distribute any savings and assign any losses based on the participating providers' respective
22 roles in the coordination and delivery of care for assigned beneficiaries. The Department shall
23 not approve an application that provides a distribution formula that apportions solely on claim
24 dollar value.

25 **"§ 108E-5. Medicaid ACO organization and governance.**

26 (a) A Medicaid ACO shall be organized as an entity recognized and authorized to
27 conduct business in North Carolina.

28 (b) A Medicaid ACO may be sponsored and constituted by any or a combination of the
29 following:

30 (1) Group practice arrangements comprised of health care providers.

31 (2) Networks of individually licensed health care providers.

32 (3) Hospitals that employ licensed health care providers.

33 (4) Joint venture arrangements of hospitals and health care providers.

34 (5) Safety net organizations such as critical access hospitals, federally qualified
35 health centers, and rural health clinics.

36 (c) A Medicaid ACO shall be managed by a designated executive and shall operate
37 under a management structure that includes both administrative and clinical controls.

38 (d) A Medicaid ACO shall be governed by a governing body having adequate authority
39 to execute statutory functions of the Medicaid ACO. Health care providers or hospital
40 representatives shall comprise the majority of the governing body and the governing body shall
41 include at least one individual who is representative of the community, who does not have a
42 conflict of interest with the ACO, and who has no immediate family member with a conflict of
43 interest with the ACO.

44 (e) An entity other than a Health Care Provider or Hospital may participate in the
45 sponsorship and governance of a Medicaid ACO, provided that such entity does not have
46 reserved powers that effectively negate the control of Medicaid ACO governance by health care
47 providers and hospitals.

48 **"§ 108E-6. Compliance and prohibited acts; cooperation with other entities.**

49 (a) A Medicaid ACO shall submit to the Department tax identification numbers (TIN)
50 and national provider identification (NPI) numbers for all participating providers.

51 (b) A Medicaid ACO must have a compliance plan that includes all of the following:

1 (c) Beneficiaries who cannot be assigned to Medicaid ACOs in accordance with
2 subsection (a) and (b) of this section, or who actively choose a PCP not affiliated with a
3 Medicaid ACO, shall be subject to care coordination under the Carolina Access program. The
4 Department may introduce into the Carolina Access program provider incentives for cost
5 efficiency and quality improvement that are comparable to the Medicaid ACO Program's
6 incentives yet suitable to the structure of Carolina Access.

7 **"§ 108E-9. Shared savings and losses.**

8 (a) The Department shall develop a formal methodology for determining a Medicaid
9 ACO payment model. The methodology shall be created with stakeholder input and shall be
10 validated by an independent actuary. The payment model shall, to the extent actuarially sound,
11 incorporate the following features:

12 (1) The set of Medicaid-covered or NC Health Choice-covered services to be
13 included in the pool of funds for which ACOs will share savings and losses;
14 such set of services shall exclude the following items:

- 15 a. Mental health, developmental disability, and substance abuse
16 services included in the capitation payments to LME/MCOs;
17 b. Dental services as defined in the Medicaid dental benefit for
18 children;
19 c. Long-term services and supports, which are nonmedical services that
20 are generally furnished to aged, blind, and disabled beneficiaries to
21 assist with activities of daily living, not for short-term post-acute care
22 or rehabilitative purposes;
23 d. Eyeglasses for children supplied by the North Carolina Department
24 of Public Safety Nash Optical Plant; and
25 e. Such other services as the Department may reasonably determine are
26 not suitable to include in the ACO incentive arrangement.

27 (2) A process to determine and establish spending benchmarks for Medicaid
28 ACOs, which shall consider:

- 29 a. Historical Medicaid health care expenditures for the beneficiary
30 population assigned to each ACO, or for a population having similar
31 eligibility status and demographic and health characteristics;
32 b. Health cost inflation trends from a base measurement period to the
33 period of contract performance;
34 c. Changes in Medicaid coverage policy or payment rates between the
35 base measurement period and the period of contract performance;
36 d. Risk adjustment in accordance with a suitable established
37 methodology that considers the identifiable health status of each
38 assigned beneficiary;
39 e. Exclusion of ninety percent (90%) of costs above a catastrophic case
40 threshold set at either fifty thousand dollars (\$50,000) or, if
41 significantly different, the 99th percentile of applicable annual
42 individual health care expenditures; and
43 f. Resetting of the benchmark effective at the beginning of the fourth
44 year of Medicaid ACO Program operations and periodically
45 thereafter at an interval that will appropriately reflect changes in
46 Medicaid health care expenditures.

47 (3) A process to compute savings and losses and the share of savings owed to
48 the ACO by the State or the share of loss owed to the State by the ACO that
49 includes the following:

- 50 a. Tabulation of actual health care expenditures incurred by
51 beneficiaries assigned to each ACO, taking into account lags between

- 1 dates of service and dates of claim payment, and removing ninety
2 percent (90%) of costs above the catastrophic case threshold;
3 b. Calculation of ACO savings or losses by subtracting actual incurred
4 expenditures from the benchmark;
5 c. For an ACO that fully meets established goals for quality of care and
6 that produces savings greater than two percent (2%) of the
7 benchmark, to award the ACO a share of savings, to include the first
8 two percent (2%); the savings share shall be sixty percent (60%) in
9 the first and second contract years, eighty percent (80%) in the third
10 contract year, and one hundred percent (100%) in the fourth and
11 subsequent contract years;
12 d. For an ACO that does not fully meet quality goals but that meets or
13 exceeds the minimum quality goals and produces savings, to reduce
14 the savings shares stated above on a sliding scale up to 20 percentage
15 points;
16 e. For an ACO that fully meets established goals for quality of care and
17 that produces a loss greater than two percent (2%) of the benchmark,
18 to recoup from the ACO a share of the loss, to include the first two
19 percent (2%); the ACO's loss share shall be forty percent (40%) in
20 the first and second contract years, sixty percent (60%) in the third
21 contract year, and eighty percent (80%) in the fourth and subsequent
22 contract years;
23 f. For an ACO that does not fully meet quality goals but that meets or
24 exceeds the minimum quality goals and produces savings, to raise the
25 loss shares stated above on a sliding scale up to 20 percentage points;
26 g. Limiting the amount owed by the State to the ACO, after all other
27 factors are taken into account, to fifteen percent (15%) of the
28 benchmark amount; and
29 h. Limiting the amount owed by the ACO to the State, after all other
30 factors are taken into account, to five percent (5%) of the benchmark
31 amount in the first contract year, seven and one-half percent (7.5%)
32 in the second, third, and fourth contract years, and ten percent (10%)
33 in the fifth and subsequent contract years.

34 (b) The Department shall devise and implement a savings and loss sharing arrangement
35 for outpatient prescription drugs whereby ACOs and LME/MCOs shall jointly participate in the
36 cost outcomes for beneficiaries that each pair of ACO and LME/MCO serves in common. Such
37 arrangement shall follow principles similar to those reflected in G.S. 108E-9(a) and shall be
38 developed with stakeholder input and validated by an independent actuary. Upon completion
39 and prior to implementation, the Department shall report on the arrangement and validation
40 from the independent actuary to the Joint Legislative Oversight Committee on Health and
41 Human Services (JLOC).

42 (c) A Medicaid ACO shall be responsible for receiving and distributing any shared
43 savings and assessing and repaying to the Division any and all shared losses. The Division shall
44 remit payment of any savings share solely to the Medicaid ACO entity and shall not have any
45 obligation to the ACO's participating providers with respect to shared savings or losses. The
46 Medicaid ACO must establish a self-executing method for repaying its share of any losses to
47 the State. Such method must be approved by the Division at the time of contract execution.

48 (d) Notwithstanding Articles 1 through 64 of Chapter 58 of the General Statutes, a
49 Medicaid ACO certified pursuant to this Chapter shall not be required to obtain certification or
50 licensure from the Department of Insurance for providing services to Medicaid beneficiaries
51 consistent with this Chapter.

"§ 108E-10. Quality measures and data.

(a) The Department, with stakeholder input, shall develop a Medicaid quality measurement protocol and establish objectively measurable goals for ACOs that identify the ranges of performance required to effectuate the savings and loss sharing provisions of G.S. 108E-9. Once developed, the Department shall report on the quality measurement protocol and objectively measurable goals for ACOs to the JLOC. Medicaid ACOs shall be required to report on the specified list of measures. The Department shall, as part of the quality measurement protocol, determine data sources for these measures. The Department may design the quality measurement protocol to expand the array of quality standards and to raise the expected levels of ACO quality performance over time.

(b) A Medicaid ACO shall be required to share clinical data from electronic health records or other sources to permit quality measurement and to enable providers not directly linked to one another to see information on patients actively in their care.

(c) The Division shall deliver to Medicaid ACOs certain identifiable service-specific data on assigned beneficiaries to be used by the ACOs and participating providers for the limited purposes of health needs assessment, care coordination, treatment, health care operations, and performance evaluation. The Division shall also make available periodic reports of the assigned beneficiaries' aggregated health care usage and cost experience.

(d) All data shared in accordance with this section shall comply with the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, (HIPAA) the rules adopted under HIPAA, and other applicable federal laws.

"§ 108E-11. Pilot projects.

The Department, subject to approval by the federal Centers for Medicare & Medicaid Services (CMS), may develop and implement one or more of the following types of pilot projects:

(1) A Medicaid ACO may propose to assume a greater degree of risk for health costs and quality than that specified in G.S. 108E-9. The Department shall undertake such an arrangement if it determines that it is administratively feasible and likely to enhance Medicaid budget predictability and sustainability and to improve quality of care.

(2) The Department may devise and test a limited set of episode-bundled payments, whereby the fees for all providers and facilities involved in the care of a patient undergoing a specified episode of treatment are consolidated into a single prospectively set payment to be made to one lead entity that will distribute portions of the payment to the constituent providers and facilities. Any bundled payments made shall count as unit payments in the accounting for Medicaid ACO savings and losses, as applicable.

The Department shall regularly report to the JLOC on the progress in implementing any pilot projects and the impact of such projects.

"§ 108E-12. State action immunity.

The North Carolina General Assembly intends to exempt activities undertaken pursuant to the Medicaid ACO Program that might otherwise be constrained by State antitrust laws and to provide immunity for such activities from federal antitrust laws through the State action immunity doctrine; however, notwithstanding this section, the General Assembly does not intend to allow and does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of State or federal antitrust laws."

SECTION 2.(b) Application for State plan amendments and waivers to implement Chapter 108E of the General Statutes, as enacted by subsection (a) of this section, shall be as follows:

(1) The Department shall apply to CMS for such State plan amendments or waivers as may be necessary to implement the provisions of this act and to

1 secure federal financial participation for State Medicaid expenditures under
2 the federal Medicaid program and shall take such additional steps as may be
3 necessary to secure on behalf of participating ACOs such as waivers,
4 exemptions, or advisory opinions to ensure that such ACOs are in
5 compliance with applicable provisions of State and federal laws related to
6 fraud and abuse, including, but not limited to, anti-kickback, self-referral,
7 false claims, and civil monetary penalties.

8 (2) The Department may apply for participation in federal ACO demonstration
9 projects that align with the goals of this act.

10 (3) The Department shall notify the General Assembly of any applications to
11 CMS for State plan amendments or waivers that are submitted in order to
12 implement the provisions of this act.

13 **SECTION 2.(c)** G.S. 150B-1(d) is amended by adding a new subdivision to read:

14 "(d) Exemptions from Rule Making. – Article 2A of this Chapter does not apply to the
15 following:

16 (26) The Department of Health and Human Services with respect to Chapter
17 108E of the General Statutes."

18 **SECTION 2.(d)** G.S. 143C-9-1(a) reads as rewritten:

19 "(a) The Medicaid Special Fund is established as a nonreverting special fund in the
20 Department of Health and Human Services. The Medicaid Special Fund shall consist of (i) the
21 federal Medicaid disproportionate share monies remaining after payments are made to
22 ~~hospitals.~~ hospitals and (ii) the State's proportioned share of savings derived under the
23 Medicaid ACO program established in Chapter 108E. Annually, the Department shall transfer
24 the disproportionate share gain, after payments are made to ~~hospitals,~~ hospitals and the derived
25 savings from the Medicaid ACO program, to the Medicaid Special Fund. Funds deposited to
26 the Medicaid Special Fund shall only be available for expenditure upon an act of appropriation
27 of the General Assembly.

28"

29 **SECTION 2.(e)** The Department shall evaluate the Medicaid ACO Program
30 annually to assess whether cost savings, including, but not limited to, savings in administrative
31 costs and savings due to improved health outcomes, are achieved through implementation of
32 the Program. The Department shall evaluate the Medicaid ACO Program annually and report
33 the results of the evaluations and any recommendations to the Joint Legislative Oversight
34 Committee on Health and Human Services.

35 **SECTION 2.(f)** Construction of act:

36 (1) Nothing in this act shall be construed to limit the choice of a Medicaid
37 beneficiary to access care for family planning services or any other type of
38 health care services from a qualified health care provider who is not
39 participating in the Medicaid ACO Program.

40 (2) Nothing in this act shall be construed to preclude the Department, qualified
41 primary care and behavioral health care providers, licensed health care
42 facilities, or any other provider or payer of health care services from
43 participating in other ACOs, health or behavioral health ACO models,
44 medical home programs, or projects.

45 **SECTION 2.(g)** The sum of one million dollars (\$1,000,000) is hereby
46 appropriated for fiscal year 2014-2015 from the General Fund to the Department of Health and
47 Human Services for the following:

48 (1) Any necessary changes to NCTracks.

49 (2) Benchmark setting and independent actuarial validation thereof.

50 (3) To otherwise implement this act.

1 **SECTION 3.** Long-Term Services and Supports. – The Department shall report to
2 the Joint Legislative Oversight Committee on Health and Human Services by February 16,
3 2015, on the findings and recommendations of the Department's strategic planning for
4 long-term services and supports for Medicaid beneficiaries.

5 **SECTION 4.** Effective Dates. – Section 2(g) of this act becomes effective July 1,
6 2014. The remainder of this act is effective when it becomes law.