



INTRODUCTION

The rollout of the Senate’s budget proposal, expected this week, was delayed and is now scheduled to begin on Monday at 4:00 pm, when each of that chamber’s Appropriations Subcommittees will meet and review their respective spending plans. Much like last week, the lack of a Senate budget plan did not prevent various other dramas from playing out. The House unveiled its Medicaid reform plan - setting up yet another showdown between the chambers on that issue - since the Senate has already rejected a similar plan. The Senate put forward its tax cut and redistribution plan (which has been condemned by municipal leaders and called “dangerous” by the Governor), as well as its economic development package, which is vastly different than the bill that the House approved and sent over. The House voted, after several days of delay, to override Gov. McCrory’s veto of Senate Bill 2, which allows court officials to opt out marriage duties because of “sincerely held religious beliefs.” And finally, one of the leading members of the House minority, 7-term Cumberland County Rep. Rick Glazier, unexpectedly announced he will retire after this year’s session to lead the NC Justice Center. Clearly, we do not need budget negotiations to keep things lively on Jones Street!

The one “big ticket” bill we expected to see but did not was the House omnibus gun bill, which was scheduled for a floor vote on Monday but was pulled by the main sponsor and sent back to the Rules committee for “more work.” With the Senate budget coming out, the House omnibus gun bill (possibly) coming back up, and more votes on the House Medicaid reform and Senate tax reform plans expected, next week may be even more exciting than the two that preceded it. As always, we will be in the thick of it and will keep you posted as things – dramatic and otherwise – unfold.



NORTH CAROLINA COLLEGE OF EMERGENCY PHYSICIANS



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BILL UPDATES

HOUSE BILL 327, Study EMS Safety/EMC Personnel Tech Changes, was amended in the Senate Health Care Committee to make technical and conforming changes to the statutes governing the regulation of emergency medical services to reflect new national standards for emergency medical personnel, including:

- renaming an emergency medical technician-intermediate as an advanced emergency medical technician; an emergency medical technician-paramedic as a paramedic; and a medical responder as an emergency medical responder; and
- requiring an ambulance when transporting a patient to be occupied by one *emergency* medical responder.

The bill also directs the North Carolina Medical Care Commission to amend its applicable rules consistent with these provisions no later than December 31, 2015. **The bill as amended was approved by the Senate Health Care Committee and will next be considered by the full Senate.**

HOUSE BILL 372, 2015 Medicaid Modernization, is the House's vision for reform of the state Medicaid system, which was rolled out this week in anticipation of the expected release of the Senate's version in that chamber's budget proposal, expected in the coming days. As was the case last session, when negotiations between the chambers broke down over this issue, the House favors a reform model that relies on physician-led and controlled "Accountable Care Organizations" (ACOs) that would be responsible for managing the care of populations within given regions, and be paid a "per-member per-month" capitated rate for their care and management of the program. The various Senate plans have all favored allowing competition between ACOs and commercial managed care companies (MCOs). Both would use networks of providers to deliver care and would be responsible for keeping costs under a proscribed level, providing the "budget certainty" the legislature has made clear it wants after years of cost overruns. Groups representing hospitals and physicians have publicly endorsed the House approach (and were credited with helping to write H372 by sponsors), while other provider groups have withheld support over issues and concerns that have been raised but are not addressed in the latest version of the bill. H372 represents the House sponsor's ideal approach to reform, and at just over 5 pages long it is not intended to address every potential issue, but has been put out as a statement of principles. Based on the number of votes against the proposal in the House Health Committee, however, it is clear that the sponsors have much work to do to convince their colleagues theirs is the best path forward. What is also clear is regardless of the fate of H372, the House and Senate are still sharply divided on the best approach to reform, and that this "long" session may be dragged out into the fall as the two sides attempt to work out their differences on the issue. As written, H372 would:

- provide that responsibility for managing the Medicaid program would be transferred to provider-led entities (PLEs), which would implement full-risk capitated health plans to manage and coordinate the care for enough program aid categories to cover at least 90% of Medicaid recipients to be phased in over five years;
- prohibit including dual-eligible individuals for whom Medicaid pays only Medicare premiums in program aid category coverage;
- require that PLEs cover Medicaid recipients in all 100 counties in the aggregate and ensure appropriate access to care for Medicaid recipients in all 100 counties while building upon the existing enhanced primary care medical home model;
- assign responsibility to the Department of Health and Human Services (DHHS) to implement a process for assigning Medicaid recipients to PLEs;

- require that PLE contracts result in controlling the State's cost growth at least two 2% 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;
- require DHHS to implement a process for recipient assignment to provider-led entities, based on the recipient's selection of a provider-led entity. If the recipient fails to choose a provider-led entity during initial enrollment, DHHS would develop a process for auto-assignment to a PLE,
- require DHHS to ensure contracts contain effective program integrity features to protect against provider fraud, waste, and abuse at all levels of the system;
- hold PLEs responsible for all administrative functions for recipients enrolled in their plan, including, but not limited to, all claims processing, care management, case management, appeals, and all other necessary administrative services;
- require that a majority of each PLE's governing board shall be comprised of physicians who treat Medicaid patients including those who provide clinical services to Medicaid patients;
- require DHHS to develop, with "meaningful stakeholder engagement" (undefined in the bill), and submit to the Centers for Medicare and Medicaid Services (CMS) a request for an 1115 Medicaid demonstration waiver within 12 months of the bill becoming law;
- require DHHS to issue a request for proposals (RFP) for PLEs to bid on contracts required under this act within 24 months of the bill becoming law and receipt of the waiver approvals from CMS;
- require that within five years of the date of the bill becoming law, 90% of Medicaid recipients in the state must be enrolled in full-risk, capitated health plans for all services other than those contracted for through the local management entities/managed care organizations (LME/MCOs), dental services, and pharmaceutical products;
- require that within six years of the bill becoming law, each PLE under contract with DHHS must meet the risk, cost, performance, and quality goals required by the bill and as contained in the contract;
- require PLEs to provide coverage for a defined population of at least 30,000 recipients and ensure appropriate access to care for recipients;
- detail individual responsibilities to be met by bidders, and collective responsibilities to be met by all bidders, as well as criteria and standards to be met by all contracts;
- delegate full authority to DHHS to take all actions that are necessary to implement the provisions of the bill, including requiring DHHS to administer and manage the program within the budget enacted by the General Assembly, provided that the total expenditures do not exceed the enacted budget;
- direct the Secretary of DHHS to convene a quality assurance advisory committee consisting of experts in the areas of Medicaid, actuarial science, health economics, health benefits, and administration of health law and policy, including at least one member of the North Carolina State Health Coordinating Council, which would advise DHHS on developing and submitting requests for all federal waivers and to support the development and approval of the performance goals that will serve as the basis of the pay-for-performance system. Provides that the committee is to terminate five years from the date of the enactment of the bill. Directs DHHS to contract for periodic financial audits of each successful bidder based on the terms and conditions of the contract awarded;
- require DHHS to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the greatest extent possible. If such Medicaid-specific funding cannot be maintained, DHHS would advise the Joint Legislative Oversight Committee (new entity created by the bill) of any necessary

modifications to maintain as much revenue as possible within the context of Medicaid transformation;

- direct DHHS to continue implementation of the existing 1915(b)/(c) waiver;
- establish a 14- member Joint Legislative Oversight Committee on Medicaid with seven members of the Senate appointed by the President Pro Tempore of the Senate and seven members of the House of Representatives appointed by the Speaker of the House of Representatives, including a minimum of two members appointed by each chamber to be members of the minority party, to “examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs and to DHHS”;
- require the Committee to make periodic reports to the General Assembly; and
- appropriate \$2.5 million in nonrecurring funds for each of the next two fiscal years to accomplish the Medicaid transformation outlined in the bill (the funds would be a state match for federal funds).

Approved by the House Health Committee and will next be heard in the House Appropriations Committee.

SENATE BILL 2, Magistrates Recusal of Civil Ceremonies. After this controversial bill was vetoed by the Governor on May 28th and the Senate voted to override the veto on June 1st, the motion to override was placed on the House calendar for 6 legislative days in a row without a vote. The given reason was too many members were absent, but it was clear there simply were not enough votes to override (the motion to override a veto requires 3/5 of the members present and voting to support it, meaning the number of necessary votes in favor changes depending on the number of members absent). During this time there was an intense lobbying push from House leaders and groups supporting the bill, as well as the Governor and groups opposed to the bill, all watching the “excused absences” list closely. On Thursday, after the leadership determined that enough members who would vote to sustain the veto were absent and enough members who would vote to override were present, the motion was brought before the members and debate was quickly cut off. The motion to override passed 69-41, and the bill immediately became law. **Governor’s veto overridden by the Senate and House, and became law on June 11.**

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