

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H.B. 1181
May 21, 2014
HOUSE PRINCIPAL CLERK

H

D

HOUSE DRH40179-MEa-115 (05/14)

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

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

Referred to:

A BILL TO BE ENTITLED

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

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

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

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

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

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

The General Assembly of North Carolina enacts:

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

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

"Chapter 108E.

"Medicaid Accountable Care Organizations.

"Article 1.

"General Provisions.



* D R H 4 0 1 7 9 - M E A - 1 1 5 *

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

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

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

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

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

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

"Article 2.

"Minimum Requirements for Medicaid ACO Program Participation.

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

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

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

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

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

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

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

22 **"§ 108E-5. Medicaid ACO organization and governance.**

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

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

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

28 **(2)** Networks of individually licensed health care providers.

29 **(3)** Hospitals that employ licensed health care providers.

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

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

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

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

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

45 **"§ 108E-6. Compliance and prohibited acts; cooperation with other entities.**

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

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

49 **(1)** A lead compliance official who reports to the governing body.

50 **(2)** Mechanisms for identifying compliance problems.

1 (3) A way for ACO providers, employees, or contractors to report suspected
2 problems.

3 (4) Compliance training.

4 (5) A requirement to report suspected violations to the appropriate law
5 enforcement agency.

6 (c) A Medicaid ACO shall maintain a conflict of interest policy approved by its
7 governing body and maintain on file with the Division the most recent version.

8 (d) A Medicaid ACO shall not engage in any activity that would prevent an assigned
9 beneficiary from receiving benefits to which the beneficiary is entitled and shall ensure that the
10 delivery of services is in the best interests of the Medicaid and NC Health Choice beneficiaries.

11 (e) A Medicaid ACO shall provide all notices and instructional materials relating to
12 assigned beneficiaries and potentially assigned beneficiaries in a manner and format that may
13 be easily understood in accordance with the provisions of federal regulations at 42 C.F.R. §
14 438.10.

15 (f) A Medicaid ACO shall be prohibited from offering gifts, cash, or other
16 remuneration to beneficiaries for choosing a particular provider or receiving services. As part
17 of bona fide health education efforts, an ACO may supply certain items or services for free or
18 below fair market value. Such items must either be preventive or advance a clinical goal for the
19 beneficiary. The Division may institute a formal approval process for such practices.

20 (g) A Medicaid ACO shall enter into, and continuously operate under, a cooperative
21 agreement with each local health department and each LME/MCO in the communities it serves
22 for the purposes of advancing whole-person care and population health improvement.

23 **"§ 108E-7. Primary Care Physicians; capacity.**

24 (a) A Medicaid ACO must include as participants PCPs that agree to perform the
25 function of a patient-centered medical home for beneficiaries that select or are assigned to
26 them. A PCP shall be affiliated with only a single Medicaid ACO at any one time; all other
27 types of health care providers and facilities may be associated with one or more Medicaid
28 ACOs for purposes of participating in the Medicaid ACO Program.

29 (b) A Medicaid ACO shall include a number and distribution of PCPs capable of
30 servng a sizeable and diverse Medicaid population and have capacity at all times to serve at
31 least 5,000 assigned Medicaid beneficiaries or a greater number of assigned beneficiaries that
32 the Department reasonably determines is sufficient to ensure stability of the risk pool. The
33 Department shall set the minimum number by rule, following validation of the number by an
34 independent actuary.

35 "Article 3.

36 "Assignment of Beneficiaries, Value-Based Payment, Quality Measurement.

37 **"§ 108E-8. Eligible beneficiary assignment.**

38 (a) An eligible beneficiary's selection of a PCP will be the basis for assigning the
39 beneficiary to a Medicaid ACO. If the beneficiary fails to enroll with a PCP within 30 days of
40 gaining Medicaid eligibility, the Division will assign the beneficiary to a PCP participating in
41 the Medicaid ACO Program using an auto-assignment process that considers selecting a PCP
42 within reasonable travel time, prohibits discrimination on the basis of health status or
43 requirements for health care, and allows the beneficiary to terminate the assignment without
44 risk of discontinued or interrupted medical services. The Division shall maintain beneficiary
45 freedom of choice with respect to selecting the PCP and ensure all applicable requirements of
46 section 1905(t) of the Social Security Act (SSA) are met.

47 (b) The Department may determine that selected classes of Medicaid beneficiaries
48 receiving limited benefits from Medicaid shall not be assigned to a Medicaid ACO due to the
49 difficulty in systematically effecting their care.

50 (c) Beneficiaries who cannot be assigned to Medicaid ACOs in accordance with
51 subsection (a) and (b) of this section, or who actively choose a PCP not affiliated with a

1 Medicaid ACO, shall be subject to care coordination under the Carolina Access program. The
2 Department may introduce into the Carolina Access program provider incentives for cost
3 efficiency and quality improvement that are comparable to the Medicaid ACO Program's
4 incentives yet suitable to the structure of Carolina Access.

5 **"§ 108E-9. Shared savings and losses.**

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

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

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

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

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

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

- 48 a. Tabulation of actual health care expenditures incurred by
49 beneficiaries assigned to each ACO, taking into account lags between
50 dates of service and dates of claim payment, and removing ninety
51 percent (90%) of costs above the catastrophic case threshold;

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

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

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

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

50 "§ 108E-10. Quality measures and data.

1 (a) The Department, with stakeholder input, shall develop a Medicaid quality
2 measurement protocol and establish objectively measurable goals for ACOs that identify the
3 ranges of performance required to effectuate the savings and loss sharing provisions of G.S.
4 108E-9. Once developed, the Department shall report on the quality measurement protocol and
5 objectively measurable goals for ACOs to the JLOC. Medicaid ACOs shall be required to
6 report on the specified list of measures. The Department shall, as part of the quality
7 measurement protocol, determine data sources for these measures. The Department may design
8 the quality measurement protocol to expand the array of quality standards and to raise the
9 expected levels of ACO quality performance over time.

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

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

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

21 **"§ 108E-11. Pilot projects.**

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

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

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

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

39 **"§ 108E-12. State action immunity.**

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

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

49 (1) The Department shall apply to CMS for such State plan amendments or
50 waivers as may be necessary to implement the provisions of this act and to
51 secure federal financial participation for State Medicaid expenditures under

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

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

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

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

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

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

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

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

27"

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

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

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

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

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

47 (1) Any necessary changes to NCTracks.

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

49 (3) To otherwise implement this act.

50 **SECTION 3.** Long-Term Services and Supports. – The Department shall report to
51 the Joint Legislative Oversight Committee on Health and Human Services by February 16,

1 2015, on the findings and recommendations of the Department's strategic planning for
2 long-term services and supports for Medicaid beneficiaries.
3 **SECTION 4.** Effective Dates. – Section 2(g) of this act becomes effective July 1,
4 2014. The remainder of this act is effective when it becomes law.