

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

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.**



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"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) A lead compliance official who reports to the governing body.
- (2) Mechanisms for identifying compliance problems.
- (3) A way for ACO providers, employees, or contractors to report suspected problems.
- (4) Compliance training.
- (5) A requirement to report suspected violations to the appropriate law enforcement agency.

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

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

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

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

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

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

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

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

"Article 3.

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

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

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

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

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.