

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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HOUSE BILL 1181
Committee Substitute Favorable 6/23/14
Committee Substitute #2 Favorable 7/2/14
Senate Rules and Operations of the Senate Committee Substitute Adopted 7/17/14
Senate Rules and Operations of the Senate Committee Substitute Adopted 7/23/14
Sixth Edition Engrossed 7/28/14

Short Title: North Carolina Medicaid Modernization.

(Public)

Sponsors:

Referred to:

May 22, 2014

1 A BILL TO BE ENTITLED
2 AN ACT TO MODERNIZE AND STABILIZE NORTH CAROLINA'S MEDICAID
3 PROGRAM THROUGH FULL-RISK CAPITATED HEALTH PLANS TO BE
4 MANAGED BY A NEW DEPARTMENT OF MEDICAL BENEFITS.

5 The General Assembly of North Carolina enacts:

6 **SECTION 1.** Intent and Goals. – It is the intent of the General Assembly to
7 transform the State's Medicaid program from a traditional fee-for-service system into a system
8 that provides budget predictability for the taxpayers of this State while ensuring quality care to
9 those in need. The new Medicaid program shall be designed to achieve the following goals:

- 10 (1) Provide budget predictability.
- 11 (2) Slow the rate of cost growth.
- 12 (3) Whole-person integrated care.
- 13 (4) Achieve cost-savings through efficient reductions in programmatic costs.
- 14 (5) Create more efficient administrative structures.
- 15 (6) Provide accountability for budget and program outcomes.
- 16 (7) Improve health outcomes for the State's Medicaid population.
- 17 (8) Maintain access to care for the State's Medicaid population.

18 **SECTION 2.** Building Blocks. – The principal building blocks of the Medicaid
19 reform directed by Section 1 of this act shall be as follows:

- 20 (1) A new Department of Medical Benefits, created in Section 10 of this act, to
21 focus on the Medicaid and NC Health Choice programs and to be managed
22 by a board of experienced business, health care, and health insurance leaders
23 appointed by the Governor and General Assembly.
- 24 (2) Full-risk capitated health plans to manage and coordinate the care for all
25 Medicaid recipients and cover all Medicaid health care items and services.
26 Once reform is fully implemented, the State's risk shall be limited to the risk
27 of enrollment numbers and enrollment mix for the capitated populations.
- 28 (3) Competition between multiple provider-led and non-provider-led health
29 plans in order to reduce costs, improve quality, and increase patient
30 satisfaction. In order to allow provider-led health plans to become
31 established, full risk for provider-led health plans shall be phased in over
32 two years. The capitated health plans authorized by this act may work in



1 collaboration with the LME/MCOs created in S.L. 2011-264 (HB 916) to
2 serve the Medicaid population.

3 (4) Regional health plans, subject to the following:

4 a. In defining regions, the Department of Medical Benefits shall
5 consider Community Care of North Carolina (CCNC) regions,
6 catchment areas of local management entities that have been
7 approved to operate as managed care organizations (LME/MCOs),
8 hospital referral patterns, or other appropriate criteria.

9 b. Multiple plans shall be offered in each region, with at least one
10 provider-led plan per region.

11 c. Notwithstanding sub-subdivision b. of this subdivision, if multiple
12 plans cannot be established for a rural area, then, as allowed by
13 42 C.F.R. 438.52, those rural areas may operate with one plan, and
14 that plan may be either provider-led or non-provider-led.

15 d. Health plans that contract to cover a rural area may be awarded a
16 contract to cover an urban area that is contingent upon continued
17 coverage in the rural area.

18 (5) Risk-adjusted capitated rates based on eligibility categories, geographic
19 areas, and clinical risk profiles of recipients.

20 (6) Participant choice of plans offering customized benefit packages that appeal
21 to and meet the varied health needs of participants.

22 (7) Mechanisms to provide incentives and encourage personal accountability for
23 Medicaid beneficiaries' participation in their own health outcomes.

24 (8) Mechanisms to (i) identify Medicaid recipients who may benefit from other
25 State services and programs to maximize their opportunities and reduce their
26 reliance on Medicaid for health coverage and (ii) refer those individuals to
27 the appropriate other services and programs.

28 (9) Strong performance measures and metrics to hold providers accountable for
29 quality outcomes.

30 **SECTION 3.** Timeline. – The following milestones for Medicaid reform should
31 occur no later than the following dates:

32 (1) When this act becomes law: New legislative oversight committee created to
33 oversee Medicaid and NC Health Choice programs.

34 (2) September 1, 2014:

35 a. New Department of Medical Benefits created.

36 b. "Essential" Medicaid and NC Health Choice positions identified by
37 Secretary of Health and Human Services to receive retention
38 payments.

39 c. Transition team identified by Secretary of Health and Human
40 Services.

41 (3) End of September 2014: Board appointments made.

42 (4) April 15, 2015: Initial report on reform plan details by Department of
43 Medical Benefits, as provided in Section 4 of this act.

44 (5) February 1, 2016: Receive final approvals from Centers for Medicare &
45 Medicaid Services (CMS) for reform plan.

46 (6) July 1, 2016:

47 a. Department of Medical Benefits designated as the single State
48 agency for the administration of Medicaid.

49 b. Beginning of capitated health plans; beginning of phase-in to full risk
50 for provider-led plans.

51 (7) July 1, 2018: Provider-led plans at full-risk.

1 **SECTION 4.** Development of Detailed Plan. – The Department of Medical
2 Benefits shall develop with stakeholder input a detailed plan for Medicaid reform that meets the
3 goals listed in Section 1 of this act and includes the building blocks listed in Section 2 of this
4 act. The plan shall provide for strategic changes to the State's Medicaid system and shall
5 include the following:

- 6 (1) Proposed waivers, including Section 1115 waivers, or State plan
7 amendments (SPAs) as may be necessary to implement and secure federal
8 financial participation in the Medicaid reform required by this act.
- 9 (2) Proposed legislation making the necessary amendments to the General
10 Statutes to enact the recommended changes to the system of governance,
11 structure, and financing.
- 12 (3) An estimate of the amount of State and federal funds necessary to implement
13 the changes. The estimate should indicate costs of each phase of
14 implementation and the total cost of full implementation.
- 15 (4) An estimate of the amount of long-term savings in State funds expected from
16 the changes. The estimate should show savings expected in each phase of
17 implementation and the total amount of savings expected from full
18 implementation on an annual basis.
- 19 (5) The details of the two-year risk phase-in for the provider-led capitated plans.
- 20 (6) The regions defined by the Department of Medical Benefits, any population
21 or provider thresholds used in defining regions, and the number of expected
22 plans per region and how many are expected to be provider-led and
23 non-provider-led.
- 24 (7) Any populations or diseases for which specialty plans may be established.
- 25 (8) Mechanisms for measuring the State's progress towards the reform goals
26 listed in Section 1 of this act.
- 27 (9) In consultation with Community Care of North Carolina (CCNC), the
28 quality metrics for evaluating provider and health plan success.
- 29 (10) Strategies for ensuring fair negotiations among provider-led plans,
30 non-provider-led plans, providers, and the Department of Medical Benefits.
- 31 (11) A recommendation of any existing State contracts that should be transferred
32 to the Department of Medical Benefits.
- 33 (12) Methods to ensure that the Department of Medical Benefits will (i) enter into
34 contracts that are advantageous to the State and (ii) properly manage the
35 contracts to hold contractors accountable.
- 36 (13) A strategy for program integrity, including how the Department of Medical
37 Benefits and the health plans will work together to ensure that Medicaid
38 dollars are spent appropriately.
- 39 (14) A robust information technology infrastructure design, including strategies
40 to (i) transfer existing data and resources at the Department of Health and
41 Human Services to the Department of Medical Benefits, (ii) monitor
42 performance of health plans, and (iii) provide information to and receive
43 information from service providers.
- 44 (15) Plans to interact with other State agencies in areas such as communications
45 with the Centers for Medicare & Medicaid Services (CMS) prior to
46 becoming the single State entity, eligibility determinations, the allocation of
47 Medicaid-related costs to the Medicaid program, the interaction of the new
48 Medicaid program with other State information technology systems, and
49 other issues that will require coordination with other State agencies.

1 (16) In consultation with the Department of Health and Human Services, options
2 to ensure the steady operation of the existing Medicaid and NC Health
3 Choice programs until the Department of Medical Benefits operates them.

4 (17) An examination of the role of counties in the Medicaid eligibility
5 determination process, and whether alternatives such as State-administered
6 or regional eligibility determination programs would be more efficient or
7 effective.

8 **SECTION 5.** Report of Detailed Plan. – By April 15, 2015, the Department of
9 Medical Benefits shall report to the General Assembly the Department's strategic plan for the
10 Medicaid reform required under Section 4 of this act. If a detailed plan cannot reasonably be
11 completed by April 15, 2015, the Department of Medical Benefits shall (i) inform the report
12 recipients by March 15 that the April 15 report will be a progress report and (ii) provide by
13 April 15 an update on the progress toward completing a plan and report on the portions of the
14 plan that have been completed. Such a report or update shall be submitted to the Joint
15 Legislative Oversight Committee on Medical Benefits and the Fiscal Research Division.

16 **SECTION 6.** Semiannual Report. – Beginning September 1, 2015, and every six
17 months thereafter until a final report on September 1, 2020, the Department of Medical
18 Benefits shall report to the General Assembly on the State's progress toward completing
19 Medicaid reform. Reports shall be due to the Joint Legislative Oversight Committee on
20 Medical Benefits.

21 **SECTION 7.** Maintain Funding Mechanisms. – In developing its detailed plan
22 under Section 4 of this act, the Department of Medical Benefits shall work with the Centers for
23 Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding
24 generated from Medicaid-specific funding streams, such as assessments, to the extent that the
25 levels of funding may be preserved. This work with CMS shall be facilitated by the Department
26 of Health and Human Services, Division of Medical Assistance, as required by subsection (a)
27 of Section 8 of this act. If such Medicaid-specific funding cannot be maintained as currently
28 implemented, then the Division shall advise the General Assembly of the modifications
29 necessary to maintain as much revenue as possible within the context of Medicaid reform. If
30 such Medicaid-specific funding streams cannot be preserved through the reform process or if
31 revenue would decrease, then the Department of Medical Benefits shall include that
32 information in the cost estimates for Medicaid reform. Additionally, such funding streams
33 should be modified so that any supplemental payments to providers are more closely aligned to
34 improving health outcomes and achieving overall Medicaid goals.

35 **SECTION 8.** DHHS Role in Reform. – (a) During the time of transition of the
36 Medicaid program into its new form, the Department of Health and Human Services, Division
37 of Medical Assistance, shall cooperate with the Department of Medical Benefits to ensure a
38 smooth transition of the Medicaid program, as well as the NC Health Choice program. The
39 Division shall facilitate communications between the Department of Medical Benefits and the
40 Centers for Medicare & Medicaid Services (CMS) and shall submit State plan amendments
41 (SPAs) as requested by the Department of Medical Benefits. The Department of Health and
42 Human Services shall cease any activities related to implementing Medicaid reform within the
43 existing Division of Medical Assistance, except for activities directly related to assisting the
44 new Department of Medical Benefits in the reform process. The Department of Medical
45 Benefits and the Department of Health and Human Services shall enter into appropriate
46 memoranda of understanding (MOUs) to define the responsibilities of each entity during the
47 Medicaid reform process.

48 **SECTION 8.(b)** The Department of Health and Human Services, Office of the
49 Secretary, shall organize a Medicaid stabilization team to do the following:

50 (1) Maintain the Medicaid and NC Health Choice programs until the transfer of
51 the Department of Medical Benefits.

- 1 (2) Work with the Department of Medical Benefits during the transition, as
2 required by subsection (a) of this section.
- 3 (3) Develop strategies to successfully complete the requirements of subdivisions
4 (1) and (2) of this subsection.
- 5 (4) Make recommendations to the Joint Legislative Oversight Committee on
6 Medical Benefits on any additional authorization or funding necessary to
7 successfully complete the requirements of subdivisions (1) and (2) of this
8 subsection.
- 9 (5) With assistance from the Office of State Human Resources, conduct
10 interviews and meetings with designated essential employees of the Division
11 of Medical Assistance to explain the transition process, including options for
12 the employees and the bonus payment system established under subsection
13 (c) of this section.
- 14 (6) No later than September 1, 2014, report to the Joint Legislative Oversight
15 Committee on Medical Benefits on the plan to communicate to employees,
16 as required by subdivision (5) of this subsection.

17 The Office shall identify the key managers, leaders, and decision makers to be part of the
18 stabilization team and, no later than September 1, 2014, shall submit a list of these people and
19 their roles to the Joint Legislative Oversight Committee on Medical Benefits.

20 **SECTION 8.(c)** The General Assembly recognizes that it will be difficult for the
21 Department of Health and Human Services to retain essential employees within the Division of
22 Medical Assistance during the transition period, but that retaining essential employees is
23 necessary to the continued operation of the Medicaid and NC Health Choice programs until the
24 programs are operated by the Department of Medical Benefits on July 1, 2016.

25 No later than September 1, 2014, the Secretary of Health and Human Services shall
26 identify and designate "essential positions" throughout the Department of Health and Human
27 Services without which the Medicaid and NC Health Choice programs cannot operate on a
28 day-to-day basis. Such positions designated by the Secretary may include any position, whether
29 subject to or exempt from the State Personnel Act or whether supervisory or nonsupervisory, as
30 long as the position is essential to the operation of Medicaid or NC Health Choice. Because the
31 designation is based on the functions to be performed and because of the nature of the bonuses
32 provided under this section, the designation of a position as essential may not be revoked and
33 the Secretary may designate both open and filled positions.

34 In order to encourage them to remain in their positions working on Medicaid and
35 NC Health Choice within the Department of Health and Human Services, employees serving in
36 positions designated as essential positions under this subsection shall be entitled to the
37 following benefits:

- 38 (1) Effective August 1, 2014, any employee working in a designated essential
39 position within the Division of Medical Assistance shall receive a bonus at
40 each pay period that is equal to five percent (5%) of the employee's earnings
41 for that period.
- 42 (2) Effective August 1, 2014, any employee working in a designated essential
43 position within the Department of Health and Human Services, but outside
44 of the Division of Medical Assistance, whose salary is paid with federal
45 Medicaid funds shall also receive a five percent (5%) bonus, paid in the
46 same manner as bonuses are paid under subdivision (1) of this section. If
47 such an employee working outside of the Division of Medical Assistance
48 does not work full-time on Medicaid issues, then the amount of the bonus
49 shall be calculated by first multiplying the employee's earnings for that
50 period by the percentage of the employee's time spent on Medicaid issues
51 and then multiplying that product by five percent (5%).

1 (3) Any employee who received bonus payments under subdivision (1) of this
2 subsection who is still employed within the Division of Medical Assistance
3 as of June 30, 2016, or who is employed within the Department of Medical
4 Benefits, shall receive a final bonus payment equal to the sum of all the
5 bonus payments that the employee had received since July 1, 2014, under
6 subdivision (1) of this section. No employee departing before June 30, 2016,
7 shall be entitled to receive any portion of such a final bonus payment, and no
8 property right is created by this subsection for employees that depart before
9 June 30, 2016.

10 The bonus payments paid under this section are made notwithstanding
11 G.S. 126-4(2) or any other provision of law. Notwithstanding G.S. 135-1(7a), bonus payments
12 paid under this section shall not count as "compensation" for purposes of the Retirement
13 System for Teachers and State Employees, nor shall the Department of Health and Human
14 Services be required to make payments to the Retirement System based on the amounts paid as
15 bonuses. Additionally, bonus payments paid under this section shall not count as
16 "compensation" or "salary" for calculating severance payments under G.S. 126-8.5 or
17 calculating unemployment benefits.

18 Effective July 1, 2014, in order to fund bonuses authorized under this subsection,
19 the sum of six hundred thousand dollars (\$600,000) is appropriated for fiscal year 2014-2015 to
20 the Department of Health and Human Services, Division of Medical Assistance, from the funds
21 appropriated in the Appropriations Act of 2014 for Medicaid reform and such funds shall be
22 used to fund the State share of such bonuses.

23 **SECTION 8.(d)** The Department of Health and Human Services and the Division
24 of Medical Assistance shall ensure that any Medicaid-related or NC Health Choice-related
25 State contract entered into after the effective date of this act contains a clause that allows the
26 Department or the Division to terminate the contract without cause upon 30 days notice. Any
27 contract signed by the Department or the Division after the effective date of this act that lacks
28 such a termination clause shall, nonetheless, be deemed to include such a clause and shall be
29 cancellable without cause upon 30 days notice.

30 **SECTION 8.(e)** G.S. 108A-54.1A(b) is amended by adding a new subdivision to
31 read:

32 "(b) The Department may submit amendments to the State Plan only as required under
33 any of the following circumstances:

34 ...

35 (7) The Department of Medical Benefits requests the Department of Health and
36 Human Services to submit an amendment."

37 **SECTION 9.** General Assembly Commitment. – The General Assembly
38 recognizes and hereby commits to allowing the time and providing the funding necessary to
39 implement the Medicaid reform required by this act. Further, the General Assembly hereby
40 commits to (i) allow the Board of the Department of Medical Benefits to manage the Medicaid
41 and NC Health Choice programs and (ii) support the budgeting process contemplated under
42 G.S. 143B-1410(a)(10), as enacted by Section 10 of this act.

43 **SECTION 10.** Creation of Medical Benefits Department. – (a) Chapter 143B of the
44 General Statutes is amended by adding the following new Article:

45 "Article 14.

46 "Department of Medical Benefits.

47 "**§ 143B-1400. Creation and organization.**

48 There is hereby established the Department of Medical Benefits (Department) to operate the
49 Medicaid and NC Health Choice programs. The Department shall be governed by a Board,
50 which shall be responsible for ensuring that the programs provide quality medical assistance to
51 eligible recipients at a predictable cost to the taxpayers of this State. The Medicaid program

1 shall be operated through full-risk capitated health plans that include all aspects of care,
2 without exceptions, so that the State bears only the risk of enrollment numbers and enrollment
3 mix.

4 **"§ 143B-1405. Board of the Department of Medical Benefits.**

5 (a) The Board shall consist of seven members to be appointed as follows:

6 (1) Three appointments by the Governor as follows:

7 a. One individual with expertise in the administration of large health
8 delivery systems.

9 b. One individual with expertise in public assistance programs.

10 c. One individual who is an actuarial fellow with experience in health
11 insurance.

12 (2) Two appointments by the General Assembly, on the recommendation of the
13 President Pro Tempore of the Senate, as follows:

14 a. One individual with expertise in managed care.

15 b. One individual with leadership experience at a large business with a
16 corporate board structure.

17 (3) Two appointments by the General Assembly, on the recommendation of the
18 Speaker of the House of Representatives, as follows:

19 a. One individual with expertise in health insurance.

20 b. One individual with leadership experience at a large business with a
21 corporate board structure.

22 (b) In addition to the seven members provided in subsection (a) of this section, the
23 Secretary of Health and Human Services, or the Secretary's designee, shall serve as an ex
24 officio nonvoting member of the Board.

25 (c) The term of office for initial appointments under this section shall be until July 1,
26 2017. After those terms expire, in order to stagger terms, the appointing authorities shall
27 designate one person appointed under subdivision (1), one appointed under subdivision (2), and
28 one appointed subdivision (3) of subsection (a) of this section to serve until July 1, 2019. The
29 remaining four appointees shall serve for four years, as shall all future appointees. Board
30 members may serve up to two consecutive terms, not including the initial term of three years or
31 the abbreviated two-year terms.

32 (d) The following individuals may not serve on the Board:

33 (1) An individual who, as a provider, receives or has received payments during
34 the year prior to serving on the Board from the North Carolina Medicaid or
35 NC Health Choice programs.

36 (2) An individual who is an employee or board member of an entity that
37 receives, or received within the year prior to the individual serving on the
38 Board, direct payments from the North Carolina Medicaid or NC Health
39 Choice programs.

40 (3) An individual who is or was during the year prior to serving on the Board an
41 employee of a provider organization with members that receive or have
42 received payments from the North Carolina Medicaid or NC Health Choice
43 programs.

44 (4) An individual who represents or has represented during the year prior to
45 serving on the Board any of the following:

46 a. A provider that receives or has received payments from the North
47 Carolina Medicaid or NC Health Choice programs.

48 b. A provider organization with members that receive or have received
49 payments from the North Carolina Medicaid or NC Health Choice
50 programs.

1 (5) An individual who is or has been a registered lobbyist for a provider
2 receiving payments from the North Carolina Medicaid or NC Health Choice
3 programs, or an employee of such a lobbyist.

4 (6) An individual who is an employee or a board member of any entity under
5 contract with the Department to provide a health plan.

6 As used in this subsection, the terms "provider" and "entity" includes any parent, subsidiary, or
7 affiliated legal entity, and the term "provider" has the same meaning as defined under
8 G.S. 108C-2.

9 (e) Appointees shall serve at the pleasure of the appointing authorities and the
10 appointing authorities shall fill any vacancies.

11 (f) The Governor shall designate a chair of the Board from among the appointed
12 members of the Board. The Board member designated as chair shall serve as chair at the
13 pleasure of the Governor. The chair shall serve on the Governor's Cabinet.

14 (g) Board members shall serve as fiduciaries for the Medicaid and NC Health Choice
15 programs and are subject to the duty of care, the duty of loyalty, and the duty of obedience as
16 established under nonprofit corporate law. These duties are in addition to any other
17 requirements placed on the Board members as public servants under Chapter 138A of the
18 General Statutes.

19 (h) Board members are not State employees.

20 (i) A majority of the members appointed under subsection (a) of this section constitutes
21 a quorum for conducting business.

22 (j) For a period of one year following the expiration of service on the Board, a board
23 member may not accept employment, or enter into a contract, with an entity described in
24 subsection (d) of this section that would have prohibited service on the Board.

25 **"§ 143B-1410. Powers and duties of Board.**

26 (a) The Board of the Department shall have the following powers and duties:

27 (1) Administer and operate the Medicaid and NC Health Choice programs.

28 (2) Employ the Medicaid Director, who shall be responsible for the daily
29 operation of the Department, and other staff, including legal staff. In hiring
30 staff, the Board may offer employment contracts for a term.

31 (3) Set compensation for the employees and Board of the Department, including
32 performance-based bonuses based on meeting budget or other targets.

33 (4) Procure office space for the Department.

34 (5) Enter into contracts for the administration of the Medicaid and NC Health
35 Choice programs, as well as manage such contracts, including contracts of a
36 consulting or advisory nature.

37 (6) Form committees of the Board.

38 (7) Define and approve the following for the Department and the programs
39 managed by the Department:

40 a. Business policy.

41 b. Strategic plans, including desired health outcomes for the covered
42 populations.

43 c. Program and policy changes.

44 d. Operational budget and assumptions.

45 (8) Establish and adjust all program components, except for eligibility, of the
46 Medicaid and NC Health Choice programs.

47 (9) Develop midyear budget correction plans and strategies and take such
48 midyear budget corrections when necessary.

49 (10) Develop and present to the General Assembly and the Office of State Budget
50 and Management by January 1 of each year, beginning in 2016, the
51 following information for the Medicaid and NC Health Choice programs:

- 1 a. A detailed five-year forecast of expected changes to enrollment
2 growth and enrollment mix.
- 3 b. What program changes will be made by the Department in order to
4 stay within the existing budget for the programs based on the next
5 year's forecasted enrollment growth and enrollment mix.
- 6 c. The cost to maintain the current level of services based on the next
7 year's forecasted enrollment growth and enrollment mix.
- 8 (11) Approve expenditures to be charged to or allocated to the Medicaid program
9 by other State departments or agencies.
- 10 (b) Notwithstanding subsection (a) of this section, until the Department of Medical
11 Benefits is designated as the single State agency for the administration and operation of the
12 Medicaid and NC Health Choice programs, (i) the Department of Health and Human Services
13 retains its authority as the single State agency and (ii) the powers of the Department of Medical
14 Benefits are limited to the extent that they conflict with the authority of the Department of
15 Health and Human Services as the single State agency. Nothing in this subsection shall be
16 construed to limit or prevent planning and preparation by the Department of Medical Benefits
17 to exercise its full authority once it is designated as the single State agency.
- 18 (c) The Board may delegate its powers and duties under this section to the Medicaid
19 Director and other staff of the Department. In delegating powers or duties, however, the Board
20 maintains the responsibility for the performance of those powers or duties.
- 21 (d) The General Assembly retains the authority to determine the eligibility requirements
22 for the Medicaid and NC Health Choice programs.
- 23 (e) Neither the Board nor the Department may enter into any contract with an entity to
24 provide a health plan if any of the following apply:
- 25 (1) That entity employs, or contracts with, a current member of the Board.
- 26 (2) That entity employs, or contracts with, a former member of the Board whose
27 service ended less than 24 months before entering into the contract.
- 28 (3) A member of the Board also serves on the governing board of the entity.
- 29 (4) A former member of the Board, whose service ended less than 24 months
30 before entering into the contract, serves on the governing board of the entity.

31 **"§ 143B-1415. Variations from certain State laws.**

32 Although generally subject to the laws of this State, the following exemptions, limitations,
33 and modifications apply to the Department of Medical Benefits, notwithstanding any other
34 provision of law:

- 35 (1) Employees of the Department shall not be subject to portions of the State
36 Personnel Act, as provided in G.S. 126-5(c13). After July 1, 2016, however,
37 the Department may designate employee positions as subject to the State
38 Personnel Act, provided that the positions so designated do not meet the
39 definition of "exempt position" under G.S. 126-5(b).
- 40 (2) The Department may choose to retain legal counsel other than the Attorney
41 General.
- 42 (3) The Department's personnel contracts are not subject to review and approval
43 by the Office of State Human Resources.
- 44 (4) If the Department establishes alternative procedures for the review and
45 approval of contracts, then the Department is exempt from State contract
46 review and approval requirements, but may still choose to utilize the State
47 contract review and approval procedures for particular contracts.
- 48 (5) The Board may move into a closed session for any of the reasons listed in
49 G.S. 143-318.11, as well as for discussions on the following:
- 50 a. Per member per month rates or other rates paid to health plans.

"§ 120-209.1. Purpose and powers of Committee.

(a) The Joint Legislative Oversight Committee on Medical Benefits shall examine budgeting, financing, administrative, and operational issues related to the following:

(1) The reform of Medicaid and the transition of the program from the Department of Health and Human Services to the Department of Medical Benefits.

(2) Any aspect of the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services, whether performed by the Division of Medical Assistance or another division of the Department.

(3) The Medicaid and NC Health Choice programs, as operated by the Department of Medical Benefits.

(b) The Committee may make interim reports to the General Assembly on matters for which it may report to a regular session of the General Assembly. A report to the General Assembly may contain any legislation needed to implement a recommendation of the Committee.

"§ 120-209.2. Organization of Committee.

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medical Benefits. The Committee shall meet upon the joint call of the cochairs and may meet while the General Assembly is in regular session.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge.

"§ 120-209.3. Additional powers.

The Joint Legislative Oversight Committee on Medical Benefits, while in discharge of official duties, shall have access to any paper or document, and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a joint committee of the General Assembly.

"§ 120-209.4. Reports to Committee.

Whenever the Department of Medical Benefits is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters affecting the Department, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Medical Benefits."

SECTION 12.(b) G.S. 120-208.1(a)(2)b. is repealed and G.S. 120-208.1(a)(1) reads as rewritten:

"(1) Study the budgets, programs, and policies of each Division ~~within the Department of Health and Human Services,~~ listed in subdivision (2) of this section to determine ways in which the General Assembly may encourage improvement in the budgeting and delivery of health and human services provided to North Carolinians;"

1 **SECTION 12.(c)** Notwithstanding any other provision of law, any reports by the
2 Department of Health and Human Services or the Division of Medical Assistance related to
3 Medicaid due during the 2014-2015 fiscal year shall be made to the Joint Legislative Oversight
4 Committee on Medical Benefits.

5 **SECTION 13.** Sections 10 and 11 become effective September 1, 2014. Except as
6 otherwise provided, this act is effective when it becomes law.