

**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
PROPOSED SENATE COMMITTEE SUBSTITUTE H1181-PCS40282-ME-25**

Short Title: North Carolina Medicaid Modernization.

(Public)

Sponsors:

Referred to:

May 22, 2014

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

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

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

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

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



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- 1 a. In defining regions, the Department of Medical Benefits shall
2 consider Community Care of North Carolina (CCNC) regions,
3 catchment areas of local management entities that have been
4 approved to operate as managed care organizations (LME/MCOs),
5 hospital referral patterns, or other appropriate criteria.
6 b. Multiple plans shall be offered in each region, with at least one
7 provider-led plan per region.
8 c. Notwithstanding sub-subdivision b. of this subdivision, if multiple
9 plans cannot be established for a rural area, then, as allowed by
10 42 C.F.R. 438.52, those rural areas may operate with one plan, and
11 that plan may be either provider-led or non-provider-led.
12 d. Health plans that contract to cover a rural area may be awarded a
13 contract to cover an urban area that is contingent upon continued
14 coverage in the rural area.

- 15 (5) Risk-adjusted capitated rates based on eligibility categories, geographic
16 areas, and clinical risk profiles of recipients.
17 (6) Participant choice of plans offering customized benefit packages that appeal
18 to and meet the varied health needs of participants.
19 (7) Mechanisms to provide incentives and encourage personal accountability for
20 Medicaid beneficiaries' participation in their own health outcomes.
21 (8) Mechanisms to (i) identify Medicaid recipients who may benefit from other
22 State services and programs to maximize their opportunities and reduce their
23 reliance on Medicaid for health coverage and (ii) refer those individuals to
24 the appropriate other services and programs.
25 (9) Strong performance measures and metrics to hold providers accountable for
26 quality outcomes.

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

- 29 (1) August 1, 2014:
30 a. New Department of Medical Benefits created.
31 b. New legislative oversight committee created to oversee Medicaid and
32 NC Health Choice programs.
33 (2) September 1, 2014:
34 a. "Essential" Medicaid and NC Health Choice positions identified by
35 Secretary of Health and Human Services to receive retention
36 payments.
37 b. Transition team identified by Secretary of Health and Human
38 Services.
39 (3) End of September 2014: Board appointments made.
40 (4) March 1, 2015: Initial report on reform plan details by Department of
41 Medical Benefits, as provided in Section 4 of this act.
42 (5) January 1, 2016: Receive final approvals from Centers for Medicare &
43 Medicaid Services (CMS) for reform plan.
44 (6) July 1, 2016:
45 a. Department of Medical Benefits designated as the single State
46 agency for the administration of Medicaid.
47 b. Beginning of capitated health plans; beginning of phase-in to full risk
48 for provider-led plans.
49 (7) July 1, 2018: Provider-led plans at full-risk.

50 **SECTION 4.** Development of Detailed Plan. – The Department of Medical
51 Benefits shall develop with stakeholder input a detailed plan for Medicaid reform that meets the

1 goals listed in Section 1 of this act and includes the building blocks listed in Section 2 of this
2 act. The plan shall provide for strategic changes to the State's Medicaid system and shall
3 include the following:

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

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

5 **SECTION 5.** Report of Detailed Plan. – By March 1, 2015, the Department of
6 Medical Benefits shall report to the General Assembly the Department's strategic plan for the
7 Medicaid reform required under Section 4 of this act. If a detailed plan cannot reasonably be
8 completed by March 1, 2015, the Department of Medical Benefits shall (i) inform the report
9 recipients by February 1 that the March 1 report will be a progress report and (ii) provide by
10 March 1 an update on the progress toward completing a plan and report on the portions of the
11 plan that have been completed. Such a report or update shall be submitted to the Joint
12 Legislative Oversight Committee on Medical Benefits and the Fiscal Research Division.

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

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

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

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

- 47 (1) Maintain the Medicaid and NC Health Choice programs until the transfer of
48 the Department of Medical Benefits.
49 (2) Work with the Department of Medical Benefits during the transition, as
50 required by subsection (a) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

32 ...
33 (7) The Department of Medical Benefits requests the Department of Health and
34 Human Services to submit an amendment."

35 **SECTION 9.** General Assembly Commitment. – The General Assembly
36 recognizes and hereby commits to allowing the time and providing the funding necessary to
37 implement the Medicaid reform required by this act. Further, the General Assembly hereby
38 commits to (i) allow the Board of the Department of Medical Benefits to manage the Medicaid
39 and NC Health Choice programs and (ii) support the budgeting process contemplated under
40 G.S. 143B-1410(a)(8), as enacted by Section 10 of this act.

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

43 "Article 14.

44 "Department of Medical Benefits.

45 **§ 143B-1400. Creation and organization.**

46 There is hereby established the Department of Medical Benefits (Department) to operate the
47 Medicaid and NC Health Choice programs. The Department shall be governed by a Board,
48 which shall be responsible for ensuring that the programs provide quality medical assistance to
49 eligible recipients at a predictable cost to the taxpayers of this State. The Medicaid program
50 shall be operated through full-risk capitated health plans that include all aspects of care,

1 without exceptions, so that the State bears only the risk of enrollment numbers and enrollment
2 mix.

3 **"§ 143B-1405. Board of the Department of Medical Benefits.**

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

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

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

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

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

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

13 a. One individual with expertise in managed care.

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

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

18 a. One individual with expertise in health insurance.

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

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

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

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

32 (1) An individual who receives or has received payments during the year prior
33 to serving on the Board, either directly as a provider or indirectly as an
34 employee or board member of a provider, from the Medicaid or NC Health
35 Choice programs.

36 (2) An individual who is or was during the year prior to serving on the Board an
37 employee of a provider organization with members that receive or have
38 received payments from the Medicaid or NC Health Choice programs.

39 (3) An individual who represents or has represented during the year prior to
40 serving on the Board any of the following:

41 a. A provider that receives or has received payments from the Medicaid
42 or NC Health Choice programs.

43 b. A provider organization with members that receive or have received
44 payments from the Medicaid or NC Health Choice programs.

45 (4) An individual who is or has been a registered lobbyist for a provider
46 receiving payments from the Medicaid or NC Health Choice programs, or an
47 employee of such a lobbyist.

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

50 As used in this subsection, the terms "provider" and "entity" includes any parent, subsidiary, or
51 affiliated legal entity.

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

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

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

11 (h) Board members are not State employees.

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

14 **"§ 143B-1410. Powers and duties of Board.**

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

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

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

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

22 (4) Procure office space for the Department.

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

26 (6) Form committees of the Board.

27 (7) Define and approve the following for the Department and the programs
28 managed by the Department:

29 a. Business policy.

30 b. Strategic plans, including desired health outcomes for the covered
31 populations.

32 c. Program and policy changes.

33 d. Operational budget and assumptions.

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

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

38 (10) Develop and present to the General Assembly by January 1 of each year,
39 beginning in 2016, the following information for the Medicaid and NC
40 Health Choice programs:

41 a. A detailed five-year forecast of expected changes to enrollment
42 growth and enrollment mix.

43 b. What program changes will be made by the Department in order to
44 stay within the existing budget for the programs based on the next
45 year's forecasted enrollment growth and enrollment mix.

46 c. The cost to maintain the current level of services based on the next
47 year's forecasted enrollment growth and enrollment mix.

48 (11) Approve expenditures to be charged to or allocated to the Medicaid program
49 by other State departments or agencies.

50 (b) Notwithstanding subsection (a) of this section, until the Department of Medical
51 Benefits is designated as the single State agency for the administration and operation of the

1 Medicaid and NC Health Choice programs, (i) the Department of Health and Human Services
2 retains its authority as the single State agency and (ii) the powers of the Department of Medical
3 Benefits are limited to the extent that they conflict with the authority of the Department of
4 Health and Human Services as the single State agency. Nothing in this subsection shall be
5 construed to limit or prevent planning and preparation by the Department of Medical Benefits
6 to exercise its full authority once it is designated as the single State agency.

7 (c) The Board may delegate its powers and duties under this section to the Medicaid
8 Director and other staff of the Department. In delegating powers or duties, however, the Board
9 maintains the responsibility for the performance of those powers or duties.

10 (d) The General Assembly retains the authority to determine the eligibility requirements
11 for the Medicaid and NC Health Choice programs.

12 **"§ 143B-1415. Variations from certain State laws.**

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

16 (1) Employees of the Department shall not be subject to portions of the State
17 Personnel Act, as provided in G.S. 126-5(c13). After July 1, 2016, however,
18 the Department may designate employee positions as subject to the State
19 Personnel Act, provided that the positions so designated do not meet the
20 definition of "exempt position" under G.S. 126-5(b).

21 (2) The Department may choose to retain legal counsel other than the Attorney
22 General.

23 (3) The Department's personnel contracts are not subject to review and approval
24 by the Office of State Human Resources.

25 (4) If the Department establishes alternative procedures for the review and
26 approval of contracts, then the Department is exempt from State contract
27 review and approval requirements, but may still choose to utilize the State
28 contract review and approval procedures for particular contracts.

29 (5) The Board may move into a closed session for any of the reasons listed in
30 G.S. 143-318.11, as well as for discussions on the following:

31 a. Per member per month rates or other rates paid to health plans.

32 b. Audits and investigations of health plan providers, including alleged
33 violations of contracts between the State and a health plan.

34 c. Development of the annual budget forecast report for the General
35 Assembly, as required by G.S. 143B-1410(a)(8).

36 d. Any report to be submitted to the General Assembly.

37 (6) Documents created for or developed during a closed session of the Board for
38 one of the reasons specifically listed in the sub-subdivisions of subdivision
39 (5) of this subsection, as well as any minutes from such a closed session of
40 the Board, that would otherwise become public record by operation of
41 Chapter 132 of the General Statutes, shall not become public record until the
42 item under discussion has been made public through the publishing of the
43 relevant rate, findings from an audit or investigation, the annual budget
44 forecast report, or a report to the General Assembly."

45 **SECTION 10.(b)** G.S. 126-5 is amended by adding a new subsection to read:

46 **"§ 126-5. Employees subject to Chapter; exemptions.**

47 ...

48 (c13) Except as to G.S. 126-13, 126-14, 126-14.1, 126-14.2, and the provisions of Articles
49 6, 7, 14, 15, and 16 of this Chapter, the provisions of this Chapter shall not apply to employees
50 of the Department of Medical Benefits, except for employees designated by the Board as
51 subject to this Chapter under G.S. 143B-1415(a)."

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

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

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

14 **"§ 120-209.3. Additional powers.**

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

20 **"§ 120-209.4. Reports to Committee.**

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

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

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

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

36 **SECTION 13.** Sections 10, 11, and 12 become effective August 1, 2014. Except as
37 otherwise provided, this act is effective when it becomes law.