

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2013

H

D

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  
PROPOSED SENATE COMMITTEE SUBSTITUTE H1181-PCS40290-ME-27

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

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

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

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

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

30               (4)    Procure office space for the Department.

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

34               (6)    Form committees of the Board.

35               (7)    Define and approve the following for the Department and the programs  
36               managed by the Department:

37                   a.    Business policy.

38                   b.    Strategic plans, including desired health outcomes for the covered  
39                   populations.

40                   c.    Program and policy changes.

41                   d.    Operational budget and assumptions.

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

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

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

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



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

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

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

8           (b)   Notwithstanding subsection (a) of this section, until the Department of Medical  
9           Benefits is designated as the single State agency for the administration and operation of the  
10          Medicaid and NC Health Choice programs, (i) the Department of Health and Human Services  
11          retains its authority as the single State agency and (ii) the powers of the Department of Medical  
12          Benefits are limited to the extent that they conflict with the authority of the Department of  
13          Health and Human Services as the single State agency. Nothing in this subsection shall be  
14          construed to limit or prevent planning and preparation by the Department of Medical Benefits  
15          to exercise its full authority once it is designated as the single State agency.

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

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

21          **"§ 143B-1415. Variations from certain State laws.**

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

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

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

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

34           (4) If the Department establishes alternative procedures for the review and  
35           approval of contracts, then the Department is exempt from State contract  
36           review and approval requirements, but may still choose to utilize the State  
37           contract review and approval procedures for particular contracts.

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

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

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

43           c.     Development of the annual budget forecast report for the General  
44           Assembly, as required by G.S. 143B-1410(a)(10).

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

46           (6) Documents created for or developed during a closed session of the Board for  
47           one of the reasons specifically listed in the sub-subdivisions of subdivision  
48           (5) of this subsection, as well as any minutes from such a closed session of  
49           the Board, that would otherwise become public record by operation of  
50           Chapter 132 of the General Statutes, shall not become public record until the  
51           item under discussion has been made public through the publishing of the

1 relevant rate, findings from an audit or investigation, the annual budget  
2 forecast report, or a report to the General Assembly."

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

4 **"§ 126-5. Employees subject to Chapter; exemptions.**

5 ...

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

10 **SECTION 10.(c)** After receiving more specifics on the Medicaid reform plan, it is  
11 the intent of the General Assembly to make additional changes to the General Statutes beyond  
12 those made in this section as necessary to effectuate the Medicaid reform plan.

13 **SECTION 11.** Initial Board Compensation. – In order to obtain quality  
14 professionals with experience managing large businesses, insurance programs, and health  
15 systems, initial compensation for members of the Board of the Department of Medical Benefits  
16 shall be the sum of eight thousand dollars (\$8,000) per month. To pay for such compensation,  
17 the sum of two hundred eighty thousand dollars (\$280,000) is allocated and appropriated to the  
18 Department of Medical Benefits from the funds appropriated in the Appropriations Act of 2014  
19 for Medicaid reform for fiscal year 2014-2015 and such funds shall be used to fund the State  
20 share of such compensation.

21 **SECTION 12.** Legislative Oversight of Medicaid. – (a) Chapter 120 of the General  
22 Statutes is amended by adding the following new Article:

23 "Article 23B.

24 "Joint Legislative Oversight Committee on Medical Benefits.

25 **"§ 120-209. Creation and membership of Joint Legislative Oversight Committee on**  
26 **Medical Benefits.**

27 (a) The Joint Legislative Oversight Committee on Medical Benefits is established. The  
28 Committee consists of 14 members as follows:

29 (1) Seven members of the Senate appointed by the President Pro Tempore of the  
30 Senate, at least two of whom are members of the minority party.

31 (2) Seven members of the House of Representatives appointed by the Speaker of  
32 the House of Representatives, at least two of whom are members of the  
33 minority party.

34 (b) Terms on the Committee are for two years and begin on the convening of the  
35 General Assembly in each odd-numbered year. Members may complete a term of service on  
36 the Committee even if they do not seek reelection or are not reelected to the General Assembly,  
37 but resignation or removal from service in the General Assembly constitutes resignation or  
38 removal from service on the Committee.

39 (c) A member continues to serve until a successor is appointed. A vacancy shall be  
40 filled within 30 days by the officer who made the original appointment.

41 **"§ 120-209.1. Purpose and powers of Committee.**

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

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

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

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

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

5 **"§ 120-209.2. Organization of Committee.**

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

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

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

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

23 **"§ 120-209.3. Additional powers.**

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

29 **"§ 120-209.4. Reports to Committee.**

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

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

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

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

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