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GENERAL ASSEMBLY OF NORTH CAROLINA
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SENATE DRS35137-TRa-11 (03/03)

Short Title:	Medicaid Modernization.	(Public)
Sponsors:	Senator Hise (Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE AND STABILIZE NORTH CAROLINA'S MEDICAID PROGRAM THROUGH FULL-RISK CAPITATED HEALTH PLANS TO CREATE AN INDEPENDENT BOARD TO GOVERN THE MEDICAID AND NC HEALTH CHOICE PROGRAMS.

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 Health Benefits Authority, created in Section 9 of this act, to focus on the Medicaid and NC Health Choice programs and to be managed by a board of experts in health administration, health insurance, health actuarial science, health economics, and health law and policy 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 nonprovider-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. The capitated health plans authorized by this act may work in collaboration with the LME/MCOs created in S.L. 2011-264 (HB 916) to serve the Medicaid population.

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

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

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

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

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

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

SECTION 3. Time Line. – The following milestones for Medicaid reform should occur no later than the following dates:

(1) When this act becomes law:
a. New Health Benefits Authority is created and appointments to the Authority Board may be made.
b. New legislative oversight committee is created to oversee Medicaid and NC Health Choice programs.

(2) October 1, 2015:
a. Division of Medical Assistance of the Department of Health and Human Services is transferred to new Health Benefits Authority.
b. Health Benefits Authority is designated as the single state agency for the administration of Medicaid and NC Health Choice.

(3) April 15, 2016:
a. Initial report on reform plan details is submitted by the Health Benefits Authority, as provided in Sections 4 and 5 of this act.

(4) February 1, 2017:
a. Receive final approvals from Centers for Medicare & Medicaid Services (CMS) for the reform plan.

(5) July 1, 2017:
a. Capitated health plans begin.
b. Phase-in to full risk for provider-led plans begins.

(6) July 1, 2019:
a. Provider-led plans assume full risk.

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

(1) Proposed waivers, including Section 1115 waivers, or State plan amendments (SPAs) as may be necessary to implement and secure federal financial participation in the Medicaid reform required by this act.

(2) Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.

(3) An estimate of the amount of State and federal funds necessary to implement the changes. The estimate should indicate costs of each phase of implementation and the total cost of full implementation.

(4) An estimate of the amount of long-term savings in State funds expected from the changes. The estimate should show savings expected in each phase of implementation and the total amount of savings expected from full implementation on an annual basis.

(5) The details of the two-year risk phase-in for the provider-led capitated plans.

(6) The regions defined by the Health Benefits Authority, any population or provider thresholds used in defining regions, and the number of expected plans per region and how many are expected to be provider-led and nonprovider-led.

(7) Any populations or diseases for which specialty plans may be established.

(8) Mechanisms for measuring the State's progress toward the reform goals listed in Section 1 of this act.

(9) In consultation with Community Care of North Carolina (CCNC), the quality metrics for evaluating provider and health plan success.

(10) Strategies for ensuring fair negotiations among provider-led plans, nonprovider-led plans, providers, and the Health Benefits Authority.

(11) A recommendation of any existing State contracts that should be transferred after June 30, 2016, to the Health Benefits Authority.

(12) Methods to ensure that the Health Benefits Authority will (i) enter into contracts that are advantageous to the State and (ii) properly manage the contracts to hold contractors accountable.

(13) A strategy for program integrity, including how the Health Benefits Authority and the health plans will work together to ensure that Medicaid dollars are spent appropriately.

(14) A robust information technology infrastructure design, including strategies to (i) after June 30, 2016, transfer existing data and resources at the Department of Health and Human Services to the Health Benefits Authority, (ii) monitor performance of health plans, and (iii) provide information to and receive information from service providers.

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

SECTION 5. Report of Detailed Plan. – By April 15, 2016, the Health Benefits Authority shall report to the General Assembly the Authority's strategic plan for the Medicaid reform required under Section 4 of this act. If a detailed plan cannot reasonably be completed by April 15, 2016, the Health Benefits Authority shall (i) inform the report recipients by March

15 that the April 15 report will be a progress report and (ii) provide by April 15 an update on the progress toward completing a plan and report on the portions of the plan that have been completed. Such a report or update shall be submitted to the Joint Legislative Oversight Committee on Medical Benefits and the Fiscal Research Division.

SECTION 6. Semiannual Report. – Beginning September 1, 2016, and every six months thereafter until a final report on September 1, 2021, the Health Benefits Authority shall report to the General Assembly on the State's progress toward completing Medicaid reform. Reports shall be due to the Joint Legislative Oversight Committee on the Health Benefits Authority.

SECTION 7. Maintain Funding Mechanisms. – In developing its detailed plan under Section 4 of this act, the Health Benefits Authority shall work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then the Health Benefits Authority shall advise the General Assembly of the modifications necessary to maintain as much revenue as possible within the context of Medicaid reform. If such Medicaid-specific funding streams cannot be preserved through the reform process or if revenue would decrease, then the Health Benefits Authority shall include that information in the cost estimates for Medicaid reform. Additionally, such funding streams should be modified so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals.

SECTION 8. Transfer DMA. – The Division of Medical Assistance (DMA) of the Department of Health and Human Services (DHHS) is hereby transferred to the Health Benefits Authority, which is created under Section 9 of this act. DMA's statutory authority, powers, duties, and functions, records, personnel, property, unexpended balances of appropriations, allocations or other funds, including the functions of budgeting and purchasing, are transferred to the Health Benefits Authority. All of DMA's prescribed powers, duties, and functions, including, but not limited to, rule making, regulation, licensing, and adoption of rules, policies, rates, regulations, and standards, and the rendering of findings, orders, and adjudications are transferred to the Board of the Health Benefits Authority. Additionally, any powers, duties, and functions performed by or in the name of DHHS for the Medicaid or NC Health Choice programs, including, but not limited to, rule making, regulation, licensing, and adoption of rules, policies, rates, regulations, and standards, and the rendering of findings, orders, and adjudications are transferred to the Board of the Health Benefits Authority.

SECTION 9. New Governing Entity. – Article 3 of Chapter 143B of the General Statutes is amended by adding the following new Part:

"Part 36.

"Health Benefits Authority.

"**§ 143B-216.80. Creation and organization.**

There is hereby established the Health Benefits Authority (Authority) of the Department of Health and Human Services (Department) to operate the Medicaid and NC Health Choice programs. The Authority shall do the following:

(1) Exercise its statutory powers independently of the Department. The Authority shall not be subject to the supervision, direction, or control of the Department.

(2) Be governed by a Board, which shall be responsible for ensuring quality health outcomes to eligible recipients at a predictable cost to the taxpayers of this State.

(3) Function as the designated single State agency for the administration of the Medicaid and NC Health Choice programs.

"**§ 143B-216.85. Board of the Health Benefits Authority.**

(a) The Board of the Health Benefits Authority shall consist of the following:
(1) Three members appointed by the Governor.
(2) Two members appointed by the General Assembly, on the recommendation of the President Pro Tempore of the Senate.
(3) Two members appointed by the General Assembly, on the recommendation of the Speaker of the House of Representatives.
(4) The Secretary of Health and Human Services, who shall serve as an ex officio nonvoting member of the Board.

(b) Each appointed member of the board shall have expertise from at least one of the following areas:
(1) The administration of large health delivery systems.
(2) Health insurance.
(3) Health actuarial science.
(4) Health economics.
(5) Health law and policy.

In making appointments to the Board under this section, each appointing authority shall consult with the other appointing authorities to ensure adequate representation from all of the areas of expertise listed in this subsection.

(c) The following individuals may not serve on the Board:
(1) An individual who receives or has received payments during the six months prior to serving on the Board for providing health care or services to enrollees of the North Carolina Medicaid or NC Health Choice programs.
(2) An individual who is or has been during the six months prior to serving on the Board a registered lobbyist for a provider, or association of providers, receiving payments from the North Carolina Medicaid or NC Health Choice programs, or an employee of such a lobbyist.

As used in this subsection, the term "provider" includes any parent, subsidiary, or affiliated legal entity, and the term "provider" has the same meaning as defined under G.S. 108C-2. The "six months prior" prohibitions provided in this section shall not apply to the initial appointments.

(d) Board appointees shall serve for a term, but an appointee may be removed by his or her appointing authority for any of the grounds set forth in G.S. 143B-13(b), (c), or (d). Appointing authorities shall fill any vacancies that arise to complete the term of the vacating board member.

(e) In making the initial appointments, the appointing authorities shall, in order to stagger terms, designate one person appointed under subdivision (1) of subsection (a) of this section, one person appointed under subdivision (2) of subsection (a) of this section, and one person appointed under subdivision (3) of subsection (a) of this section to serve until June 30, 2017. The remaining four appointees shall serve until June 30, 2019. Future appointees shall serve terms of four years, with staggered terms based on this section. Board members may serve up to two consecutive terms, not including the abbreviated two-year terms that establish staggered terms or terms of less than two years that result from the filling of a vacancy.

(f) The Board shall elect a chair from among the voting members of the Board.

(g) The Board shall meet at least monthly until July 1, 2017, and at least quarterly thereafter. The Board may also meet at the call of the chair or at the request of a majority of the voting Board members. A majority of the voting Board members constitutes a quorum for conducting business.

(h) Board members shall serve as fiduciaries for the Medicaid and NC Health Choice programs and are subject to the duty of care, the duty of loyalty, and the duty of obedience as established under nonprofit corporate law. These duties are in addition to any other

requirements placed on the Board members as public servants under Chapter 138A of the General Statutes.

(i) Board members are State officers and not State employees.

(j) The voting members of the Board shall be compensated. The compensation for Board members established under G.S. 143B-216.90(3) shall be comparable to compensation paid to the members of boards of corporations managing large hospital systems or operating large health insurance plans, but shall not exceed the highest compensation paid to a member of the Council of State. Compensation shall be in an amount sufficient to obtain quality professionals with experience managing large businesses, insurance programs, and health systems. When adjusting members' compensation, the Board shall provide a justification to the Office of State Human Resources based upon a survey of comparable large hospital systems and health insurance plans.

"**§ 143B-216.90. Powers and duties of the Board of the Health Benefits Authority.**

(a) The Board of the Health Benefits Authority shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

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

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

(4) Procure office space for the Authority, including, if the Board so chooses, office space that is co-located with employees of the Department of Health and Human Services.

(5) Enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature. The Authority may contract with any governmental agency, person, association, or corporation to accomplish its duties and responsibilities. The Authority is encouraged, but not required, to contract with the Department of Health and Human Services when possible.

(6) Employ or contract for independent internal auditing staff that report directly to the Board rather than to the Medicaid Director. Notwithstanding subsection (b) of this section, this function may not be delegated.

(7) Pursuant to G.S. 108A-1, supervise the county departments of social services in their administration of eligibility determinations. Pursuant to subdivision (5) of this subsection, the Board may contract with the Department of Health and Human Services or any other appropriate party to perform this task or a portion of this task.

(8) Define and approve the following for the Authority and the programs managed by the Authority:

a. Business policy.

b. Strategic plans, including desired health outcomes for the covered populations, which shall do the following:

1. Be developed at a frequency of no less than every five years with the input of stakeholders.

2. Identify key opportunities and challenges facing the organization.

3. Identify the Authority's strengths and weaknesses to address these opportunities and challenges.
4. Identify key goals for the Authority for this time period, consistent with the reform goals identified by the General Assembly.
5. Identify output and outcome performance measures to quantify the Authority's progress toward these goals.
6. Identify strategies to reach these goals.
7. Be used as a guide for units within the Authority to establish unit-specific operational plans at the same frequency.

c. Performance management system, including quantitative indicators for goals and objectives, which shall do the following:
1. Be developed and implemented within the first year of the creation of the Authority, and updated no less than annually thereafter with available data.
2. Establish quantitative performance measures focusing on the quality and efficiency of service delivery and administration, using a nationally recognized quality improvement effort allowing comparison of North Carolina to other states as those developed by, but not limited to, the federal Medicaid Quality Measurement Program and the Baldridge Quality Program.
3. Establish measurable objectives for each goal identified in the strategic plan, and performance updated annually.
4. Establish, for each objective, benchmark activities, including an estimated date of completion, the area for which efforts are attempting a change, a quantitative indicator of success for the area, and quarterly milestones allowing Authority managers and employees to monitor progress throughout the year.
5. Establish mechanisms for obtaining data necessary for the collection and public distribution of performance information.

d. Program and policy changes.
e. Operational budget and assumptions.

(9) Establish and adjust all program components, except for eligibility, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.
(10) Adopt rules related to the Medicaid and NC Health Choice programs.
(11) Serve as trustees of the Medicaid Reserve Account established under G.S. 143B-216.105.
(12) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.
(13) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other divisions of the Department of Health and Human Services or by other State departments or agencies.
(14) Develop and present to the General Assembly and the Office of State Budget and Management by January 1 of each year, beginning in 2016, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.
b. What program changes will be made by the Authority in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.
c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(15) Secure and pay for the services of the State Auditor's Office to conduct annual audits of the financial accounts of the Authority.

(16) Publish the Annual Medicaid Report, which shall contain, at a minimum, the following:
a. Details on the Authority's performance over the prior four years on the following:
1. The identified quantitative measures from its strategic plan and performance management system.
2. A comparison of the identified quantitative measures from its strategic plan and performance management system and other states participating in the quality improvement effort.
b. Annual audited financial statements.

(17) Publish in an electronic format, and update on at least a monthly basis, at least the following information about the Medicaid and NC Health Choice programs:
a. Enrollment by program aid category by county.
b. Per member per month spending by category of service.
c. Spending and receipts by fund along with a detailed variance analysis.
d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(b) The Board may delegate any of its powers and duties to the Medicaid Director and other staff of the Authority. In delegating powers or duties, however, the Board maintains the responsibility for the performance of those powers or duties.

(c) The General Assembly retains the authority to determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs.

"**§ 143B-216.95. Variations from certain State laws.**

Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Health Benefits Authority, notwithstanding any other provision of law:

(1) Any employee position within the Authority created on or after October 1, 2015, or that becomes vacant on or after October 1, 2015, shall not be subject to portions of the State Personnel Act, as provided in G.S. 126-5(c13). After July 1, 2017, however, the Board of the Authority may designate employee positions as subject to the State Personnel Act, provided that the positions so designated do not meet the definition of "exempt position" under G.S. 126-5(b).

(2) The Authority may have its own legislative liaison, who shall be in addition to any that the Department of Health and Human Services is allowed under law.

(3) The Authority may choose to retain legal counsel other than the Attorney General.

(4) The Authority's employment contracts offered pursuant to G.S. 143B-216.90(a)(2) are not subject to review and approval by the Office

of State Human Resources. The Authority's employment of supplementary staff for temporary work is not subject to review and approval by the Office of State Human Resources.

(5) If the Authority establishes alternative procedures for the review and approval of contracts, then the Authority is exempt from State contract review and approval requirements, but may still choose to utilize the State contract review and approval procedures for particular contracts.

(6) The Authority shall submit its budget proposal to be included in the Governor's Recommended State Budget directly to the Office of State Budget and Management, rather than submitting it through the Office of Central Management and Support at the Department of Health and Human Services.

(7) The Secretary of Health and Human Services may not transfer funds into or out of the budget of, or any funds controlled by, the Health Benefits Authority without the approval of the Board of the Authority.

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

a. Rates, contract amounts, or any other amounts to be paid to any entity, including the amount of any transfers to a division of the Department of Health and Human Services or to any other State agency or division.

b. Audits and investigations.

c. Development of the annual budget forecast report for the General Assembly, as required by G.S. 143B-216.90(a)(14).

d. Development of a strategic plan.

e. Any report to be submitted to the General Assembly.

(9) Documents created for, or developed during, a closed session of the Board for one of the reasons specifically listed in the sub-subdivisions of subdivision (8) of this section, as well as any minutes from such a closed session of the Board, that would otherwise become public record by operation of Chapter 132 of the General Statutes, shall not become public record until the item under discussion has been made public through the publishing of the relevant rate or amount, findings from an audit or investigation, the annual budget forecast report, the strategic plan, or a report to the General Assembly.

"**§ 143B-216.100. Cooling off period for certain Health Benefits Authority employees.**

(a) Neither a Health Benefits Authority employee who, in the six months immediately preceding termination of State employment, participated personally and substantially in the award or management of a State contract with an entity, nor an immediate family member of such a Health Benefits Authority employee shall either prior to or within a period of six months immediately after termination of employment, knowingly accept employment with, commence employment with, or receive compensation for services from, such a contracting entity.

(b) Neither a Health Benefits Authority executive officer nor an immediate family member of such an executive officer shall either prior to or within a period of six months immediately after termination of employment, knowingly accept employment with, commence employment with, or receive compensation for services from, an entity that contracts with the Health Benefits Authority.

(c) Any person who violates this section, or solicits or conspires with a person to violate this section, shall be guilty of a Class 3 misdemeanor and shall be fined in an amount no less than one thousand dollars ($1,000), nor more than five thousand dollars ($5,000).

(d) As used in this section, (i) the term "contract" does not include provider enrollment agreements, (ii) the term "entity" includes any parent, subsidiary, or affiliated legal entity, and (iii) the term "immediate family member" means a spouse, child, sibling, parent, grandparent, or grandchild, or the spouse of an immediate family member, and includes stepparents, stepchildren, stepsiblings, and adoptive relationships.

"**§ 143B-216.105. Medicaid Reserve Account.**

(a) The Medicaid Reserve Account is established as a nonreverting reserve in the General Fund. The purpose of the Medicaid Reserve Account is to provide for unexpected budgetary shortfalls within the Medicaid and NC Health Choice programs that result from program expenditures in excess of the amount appropriated for the Medicaid and NC Health Choice programs by the General Assembly and which continue to exist after the Health Benefits Authority makes its best efforts to control costs through midyear budget corrections under G.S. 143B-216.90(a)(12).

(b) The Medicaid Reserve Account shall have the following minimum and maximum target balances:

(1) Minimum target. – Nine percent (9%) of a given fiscal year's General Fund appropriations for claims expenditures for both the Medicaid and NC Health Choice programs.

(2) Maximum target. – Twenty-five percent (25%) of a given fiscal year's General Fund appropriations for claims expenditures for both the Medicaid and NC Health Choice programs.

(c) Notwithstanding G.S. 143C-1-2(b), any funds appropriated to the Health Benefits Authority for the Medicaid or NC Health Choice programs and that remain unencumbered at the end of a fiscal year shall, rather than revert to the General Fund, be credited to the Medicaid Reserve Account. Any funds to be deposited in the Medicaid Reserve Account that would cause the fund balance to exceed the maximum target balance for the Medicaid Reserve Account shall instead be credited to the General Fund.

(d) The Medicaid Reserve Account may be accessed by the Health Benefits Authority to manage budgetary shortfalls in the Medicaid and NC Health Choice programs only after all of the following occur:

(1) The Board of the Health Benefits Authority certifies that there is a projected Medicaid shortfall in the current fiscal year.

(2) The Health Benefits Authority has already made midyear budget corrections under G.S. 143B-216.90(a)(12), but those midyear budget corrections have not achieved the projected budget savings.

(3) The Health Benefits Authority reports to the Joint Legislative Commission on Governmental Operations on its intent to access the Medicaid Reserve Account. The report shall include a detailed analysis of receipts, payments, claims, and transfers, including an identification of and explanation of the recurring and nonrecurring components of the shortfall.

Medicaid Reserve Account funds may be accessed in accordance with this subsection even if it results in the fund balance falling below the minimum target balance for the Medicaid Reserve Account."

SECTION 10. Board Start-Up. – (a) Notwithstanding the date provided in this act for when the Board begins to govern the Medicaid and NC Health Choice programs, the Board of the Health Benefits Authority may meet prior to October 1, 2015, in order to plan. The Board may begin meeting as soon as a majority of the appointments have been made, upon the call of a majority of members appointed as of that time. Prior to October 1, 2015, Board meetings shall be staffed by the Division of Medical Assistance.

SECTION 10.(b) As provided in G.S. 143B-216.85(j), as enacted by Section 9 of this act, compensation for the members of the Board of the Health Benefits Authority shall be

"comparable to compensation paid to the members of boards of corporations managing large hospital systems or operating large health insurance plans." Initial compensation for members of the Board (i) shall be set by the Office of State Human Resources based on a survey of compensation paid to the members of comparable boards of corporations managing large hospital systems or operating large health insurance plans and based on G.S. 143B-216.85(j) and (ii) shall be in an amount sufficient to obtain quality professionals with experience managing large businesses, insurance programs, and health systems. The Office of State Human Resources shall complete the survey and set the compensation for the Board members no later than October 1, 2015. An appointed Board member shall begin receiving compensation when the Board begins meeting. It is the intent of the General Assembly to appropriate recurring funds for Board compensation within the Current Operations and Capital Improvements Appropriations Act of 2015.

SECTION 11. Continuation of Existing Administrative Arrangements. – Notwithstanding its authority granted in subdivisions (4), (5), (7), and (13) of G.S. 143B-216.90(a), as enacted by Section 9 of this act, the Health Benefits Authority shall continue to utilize existing administrative arrangements and Medicaid cost allocations between the Division of Medical Assistance and the Department of Health and Human Services, as well as between the Division and other State departments and agencies, through June 30, 2016. The Authority has full authority to negotiate changes to those administrative arrangements and Medicaid and NC Health Choice cost allocations as authorized under G.S. 143B-216.90(a) to begin on or after July 1, 2016.

SECTION 12. Report on Cost Allocation. – No later than August 1, 2015, and in order to aid the Board of the Health Benefits Authority created by this act, the Department of Health and Human Services shall report on the allocation of Medicaid costs to Divisions outside of the Division of Medical Assistance as well as to other State departments or agencies. The Department shall submit its report to the members of the Board of the Health Benefits Authority and to the Joint Legislative Oversight Committee on Health and Human Services.

SECTION 13. Single State Agency SPAs. – (a) The Department of Health and Human Services (DHHS) shall submit the appropriate State Plan Amendments (SPAs) to change the single State agency designations for the Medicaid and NC Health Choice programs to be the Health Benefits Authority rather than DHHS. DHHS shall also submit any appropriate SPAs to make appropriate conforming changes to the State Plans to update the name of the single State agency.

SECTION 13.(b) The SPAs required by this section shall have effective dates of October 1, 2015. Notwithstanding G.S. 108A-54.1A(e), DHHS does not have to submit the SPAs required by this section 90 days in advance of October 1, 2015, but shall submit the SPAs as soon as possible after the effective date of this section and no later than September 1, 2015.

SECTION 14. Transfer of Rules, Contracts, Legal Actions. – (a) Consistent with Section 8 of this act, all rules and policies exempted from rule making related to the Medicaid and NC Health Choice programs transfer to the Health Benefits Authority.

SECTION 14.(b) Consistent with Section 8 of this act, any existing contracts with the Division of Medical Assistance that were entered into prior to the effective date of this section transfer to the Health Benefits Authority. If an existing contract entered into prior to the effective date of this section is solely for the benefit of the Division of Medical Assistance, the Medicaid program, or the NC Health Choice program, but is in the name of the Department of Health and Human Services, then the contract also transfers to the Health Benefits Authority. If an existing contract that was entered into prior to the effective date of this section (i) is in the name of the Department of Health and Human Services, (ii) is for the benefit of the Division of Medical Assistance, the Medicaid program, or the NC Health Choice program, and (iii) also benefits other portions of the Department, then the Health Benefits Authority and the Department shall enter into memorandums of understanding (MOUs) or other appropriate

agreements to define the two entities' roles and responsibilities under the contract. The Department of Health and Human Services may not enter into any new contracts, or renew or extend any contracts that existed prior to the effective date of this section, related to the Medicaid or NC Health Choice programs without the express prior approval of the Board of the Health Benefits Authority.

SECTION 14.(c) Consistent with Section 8 of this act, for any legal action involving the Medicaid or NC Health Choice programs in which the Division of Medical Assistance or the Department of Health and Human Services is named as a party, the Health Benefits Authority may be joined as a party by reason of transfer of interest upon motion of any party pursuant to Rule 25(d) of the North Carolina Rules of Civil Procedure. This subsection shall not be construed to limit any other opportunities for joinder or intervention that are otherwise allowed under the North Carolina Rules of Civil Procedure or elsewhere under law.

SECTION 15. Legislative Oversight of Medicaid. – (a) Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on the Health Benefits Authority.

"**§ 120-209. Creation and membership of Joint Legislative Oversight Committee on the Health Benefits Authority.**

(a) The Joint Legislative Oversight Committee on the Health Benefits Authority is established. The Committee consists of 14 members as follows:

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

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

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

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

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

(a) The Joint Legislative Oversight Committee on the Health Benefits Authority shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs and to the Health Benefits Authority of the Department of Health and Human Services.

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

SECTION 15.(b) G.S. 120-208.1(a)(2)b. is repealed.

SECTION 16. Recodification; Technical and Conforming Changes. – (a) The Revisor of Statutes shall recodify existing law related to Medicaid and NC Health Choice, including Parts 6, 6A, 7, and 8 of Article 2, Article 5, and Article 7 of Chapter 108A of the General Statutes, as well as Chapters 108C and 108D of the General Statutes, into a new Chapter 108E of the General Statutes to be entitled "Medicaid and NC Health Choice Health Benefit Programs" and to have the following structure:

Article 1. Administration of the Medicaid and NC Health Choice Programs
- Part 1. Establishment of the Medicaid Program
- Part 2. Establishment of the NC Health Choice Program
- Part 3. Administration by County Departments of Social Services

Article 2. Medicaid and NC Health Choice Eligibility
- Part 1. In General
- Part 2. Eligibility for Medicaid
- Part 3. Eligibility for NC Health Choice

Article 3. Medicaid and NC Health Choice Benefits and Cost-Sharing
- Part 1. In General
- Part 2. Medicaid Benefits and Cost-Sharing
- Part 3. NC Health Choice Benefits and Cost-Sharing

Article 4. Medicaid and NC Health Choice Provider Requirements
- Part 1. Provider Enrollment
- Part 2. Provider Reimbursement and Recovery
- Part 3. Hospital Assessment Act
- Part 4. Other

Article 5. Third-Party Liability
- Part 1. In General
- Part 2. Subrogation
- Part 3. Insurance
- Part 4. Estate Recovery

Article 6. Fraud and Criminal Activity

Article 7. Appeals

Part 1. Eligibility Appeals for Medicaid and NC Health Choice
Part 2. Benefit Appeals for Medicaid
Subpart 1. Generally
Subpart 2. Medicaid Managed Care for Behavioral Health Services Appeals
Part 3. Benefit Reviews for NC Health Choice
Part 4. Provider Appeals

When recodifying, the Revisor is authorized to change all references to the North Carolina Department of Health and Human Services or to the Division of Medical Assistance to instead be references to the Health Benefits Authority. The Revisor may separate subsections of existing statutory sections into new sections and, when necessary to organize relevant law into its proper place in the above structure, may rearrange sentences that currently appear within subsections. The Revisor may modify statutory citations throughout the General Statutes, as appropriate, and may modify any references to statutory divisions, such as "Chapter," "Article," "Part," "section," or "subsection." Within Articles 4 and 5 of Chapter 108A of the General Statutes, the Revisor of Statutes shall append to each reference to the North Carolina Department of Health and Human Services or to the Secretary of the Department the language "and, with respect to Medicaid and NC Health Choice, the Health Benefits Authority." The Revisor shall consult with the Department of Health and Human Services and the new Health Benefits Authority on this recodification.

SECTION 16.(b) G.S. 108A-1 reads as rewritten:

"**§ 108A-1. Creation.**

Every county shall have a board of social services or a consolidated human services board created pursuant to G.S. 153A-77(b) which shall establish county policies for the programs established by this Chapter in conformity with the rules and regulations of the Social Services Commission and under the supervision of the Department of Health and Human Services. Provided, however, county policies for the program of medical assistance shall be established in conformity with the rules and regulations of the Health Benefits Authority of the Department of Health and Human Services."

SECTION 16.(c) G.S. 108A-54.1A reads as rewritten:

"**§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

(a) ~~No provision in the Medicaid State Plan or in a Medicaid Waiver may expand or otherwise alter the scope or purpose of the Medicaid program from that authorized by law enacted by the General Assembly. For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.~~The Authority is expressly authorized and required to take any and all necessary action to amend the State plan and waivers in order to keep the program within the certified budget.

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

~~(1) A law enacted by the General Assembly directs the Department to submit an amendment to the State Plan.~~

~~(2) A law enacted by the General Assembly makes a change to the Medicaid Program that requires approval by the federal government.~~

~~(3) A change in federal law, including regulatory law, or a change in the interpretation of federal law by the federal government requires an amendment to the State Plan.~~

~~(4) A change made by the Department to the Medicaid Program requires an amendment to the State Plan, if the change was within the authority granted to the Department by State law.~~

~~(5) An amendment to the State Plan is required in response to an order of a court of competent jurisdiction.~~

~~(6) An amendment to the State Plan is required to ensure continued federal financial participation.~~

~~(c) Amendments to the State Plan submitted to the federal government for approval shall contain only those changes that are allowed by the authority for submitting an amendment to the State Plan in subsection (b) of this section.~~

(d) No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on the Health Benefits Authority and the Fiscal Research Division that the amendment has been posted. This requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval. ~~The amendment shall remain posted on the Department's Web site at least until the plan has been approved, rejected, or withdrawn. If the authority for submitting the amendment to the State Plan is pursuant to subdivision (3), (4), (5), or (6) of subsection (b) of this section, then, prior to submitting an amendment to the federal government, the Department shall submit to the General Assembly members receiving notice under this subsection and to the Fiscal Research Division an explanation of the amendment, the need for the amendment, and the federal time limits required for implementation of the amendment.~~

~~(e) The Department shall submit an amendment to the State Plan to the federal government by a date sufficient to provide the federal government adequate time to review and approve the amendment so the amendment may be effective by the date required by the directing authority in subsection (b) of this section. Additionally, if a change is made to the Medicaid program by the General Assembly and that change requires an amendment to the State Plan, then the amendment shall be submitted at least 90 days prior to the effective date of the change as provided in the legislation.~~

(f) Any public notice required under 42 C.F.R. 447.205 shall, in addition to any other posting requirements under federal law, be posted on the Department's Web site. Upon posting such a public notice, the Department shall notify the members of the Joint Legislative Oversight Committee on the Health Benefits Authority and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."

SECTION 16.(d) Part 1 of Article 2 of Chapter 108E of the General Statutes, created by the recodification process described in subsection (a) of this section, shall include the following two new sections:

"**§ 108E-2-1. General Assembly sets eligibility categories.**

Eligibility categories and income thresholds are set by the General Assembly, and the Authority shall not alter the eligibility categories and income thresholds from those authorized by the General Assembly. The Authority is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with parameters set by the General Assembly.

"**§ 108E-2-2. Counties determine eligibility.**

Counties determine eligibility in accordance with Chapter 108A of the General Statutes."

SECTION 16.(e) G.S. 126-5 is amended by adding a new subsection to read:

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

…

(c13) Except as to G.S. 126-13, 126-14, 126-14.1, 126-14.2, and the provisions of Articles 6, 7, 14, 15, and 16 of this Chapter, the provisions of this Chapter shall not apply to employees of the Health Benefits Authority in positions created or vacated after October 1, 2015, except for employees designated by the Board as subject to this Chapter under G.S. 143B-216.95(1)."

SECTION 16.(f) G.S. 143B-138.1(a)(3) is repealed.

SECTION 16.(g) G.S. 143B-153 reads as rewritten:

"**§ 143B-153. Social Services Commission – creation, powers and duties.**

There is hereby created the Social Services Commission of the Department of Health and Human Services with the power and duty to adopt rules and regulations to be followed in the conduct of the State's social service programs with the power and duty to adopt, amend, and rescind rules and regulations under and not inconsistent with the laws of the State necessary to carry out the provisions and purposes of this Article. Provided, however, the Health Benefits Authority of the Department of Health and Human Services shall have the power and duty to adopt rules and regulations to be followed in the conduct of the State's medical assistance program.

…."

SECTION 16.(h) G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

…

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

…

(9) The Health Benefits Authority of the Department of Health and Human Services in adopting new or amending existing medical coverage policies for the State Medicaid and NC Health Choice programs pursuant to G.S. 108A-54.2.

…

(20) The Health Benefits Authority of the Department of Health and Human Services in implementing, operating, or overseeing new 1915(b)/(c) Medicaid Waiver programs or amendments to existing 1915(b)/(c) Medicaid Waiver programs.

…

(22) The Health Benefits Authority of the Department of Health and Human Services with respect to the content of State Plans, State Plan Amendments, and Waivers approved by the Centers for Medicare and Medicaid Services (CMS) for the North Carolina Medicaid Program and the NC Health Choice program.

…

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

…

(17) The Health Benefits Authority of the Department of Health and Human Services with respect to the review of North Carolina Health Choice Program determinations regarding delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services.

…."

SECTION 17. Funds are appropriated from the General Fund in an amount sufficient to pay for the requirements of this act.

SECTION 18. Sections 8, 14, 15, and 16 become effective October 1, 2015. The remainder of this act is effective when it becomes law.