GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 372

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Short Title: Medicaid Transformation and Reorganization. (Public)

Sponsors:

Referred to:

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO TRANSFORM AND REORGANIZE NORTH CAROLINA'S MEDICAID AND NC HEALTH CHOICE PROGRAMS.

The General Assembly of North Carolina enacts:

PART I. TRANSFORMATION OF MEDICAID AND NC HEALTH CHOICE PROGRAMS

SECTION 1. Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid and NC Health Choice programs to programs that provide budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid and NC Health Choice programs shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.
(2) Ensure balanced quality, patient satisfaction, and financial measures.
(3) Ensure efficient and cost-effective administrative systems and structures.
(4) Ensure a sustainable delivery system.

SECTION 2. Role of the General Assembly. – The General Assembly shall have the following roles and responsibilities in Medicaid and NC Health Choice transformation and governance:

(1) Define the overall goals of transformation and the structure of the delivery system for the programs.
(2) Monitor the development of transformation plans and implementation through the Joint Legislative Oversight Committee on Medicaid and NC Health Choice.
(3) Define and approve eligibility and income standards for the programs, including which populations will be covered by Prepaid Health Plans (PHPs).

(4) Appropriate the annual budget for the Medicaid and NC Health Choice programs.

(5) Confirm the Director of the Division of Health Benefits, as required by G.S. 143B-216.85, enacted by Section 12 of this act.

SECTION 3. Time Line for Medicaid Transformation. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. –

a. The Division of Health Benefits of the Department of Health and Human Services (DHHS) is created pursuant to Section 10 of this act.

b. The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is created pursuant to Section 15 of this act to oversee the Medicaid and NC Health Choice programs.

c. The Division of Health Benefits shall begin development of the 1115 waiver and any other State Plan amendments and waiver amendments necessary to effectuate the Medicaid transformation required by this act.

(2) March 1, 2016. – The DHHS, through the Division of Health Benefits, shall report its plans and progress on Medicaid transformation, including recommended statutory changes, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, as required by subdivision (12) of Section 5 of this act.

(3) On or before June 1, 2016. – The DHHS, through the Division of Health Benefits shall submit the waivers and State Plan amendments required by this act to the Centers for Medicare & Medicaid Services (CMS).

(4) Eighteen months after approval of all necessary waivers and State Plan amendments by CMS. – Capitated contracts shall begin and initial recipient enrollment shall be complete.

SECTION 4. Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

(1) DHHS authority. – The Department of Health and Human Services (DHHS) shall have full authority to manage the State's Medicaid and NC Health Choice programs provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program, except the General Assembly shall determine eligibility categories and income thresholds. DHHS through the Division of Health Benefits, created in Section 10 of this act, shall be responsible for planning and implementing the Medicaid transformation required by this act.

(2) Prepaid Health Plan. – For purposes of this act, a Prepaid Health Plan (PHP) shall be defined as an entity, which may be a commercial plan or provider-led entity, that operates or will operate a capitated contract for the delivery of services pursuant to subdivision (3) of this section. For purposes of this act, the terms "commercial plan" and "provider-led entity" are defined as follows:

a. Commercial plan or CP. – Any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by the Department of Insurance.

b. Provider-led entity or PLE. – An entity that meets all of the following criteria:
1. A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers.
2. A majority of the entity's governing body is composed of physicians, physician assistants, nurse practitioners, or psychologists.
3. Holds a PHP license issued by the Department of Insurance.

(3) Capitated contracts. – The Division of Health Benefits, created in Section 10 of this act, shall enter into capitated contracts with PHPs for the delivery of Medicaid and NC Health Choice services as specified in this act. All capitated contracts shall be the result of requests for proposals (RFPs) issued by the Division of Health Benefits and the submission of competitive bids by PHPs, pursuant to subdivision (6) of Section 5 of this act.

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) shall be excluded from the capitated contracts until four years after the date capitated contracts begin. The capitated contracts required by this subdivision shall not cover dental services.

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except recipients who are dually eligible for Medicaid and Medicare. Recipients in the aged program aid category that are eligible for Medicare shall be considered recipients who are dually eligible for Medicaid and Medicare. The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act.

(6) Number and nature of capitated PHP contracts. – The number and nature of the contracts required under subdivision (3) of this section shall be as follows:
a. Three contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid and NC Health Choice recipients statewide (statewide contracts).
b. Up to 10 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to subdivision (2) of Section 5 of this act (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services required by subdivision (4) of this section. A PLE may bid for more than one regional contract, provided that the regions are contiguous.

c. Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State.

(6a) To the extent allowed by Medicaid federal law and regulations and consistent with the requirements of this act, PHPs shall comply with the requirements of Chapter 58 of the General Statutes. This requirement shall not be construed to require PHPs to cover services that are not covered by the Medicaid program pursuant to federal law and regulations. The Department of Health and Human Services, Division of Health Benefits, and the Department of Insurance shall jointly review the applicability of provisions of Chapter 58 of the General Statutes to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on the following:

a. Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.

b. Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.

c. Proposed statutory changes necessary to implement this subdivision.

(7) Defined measures and goals. – The new delivery system and capitated PHP contracts shall be built on defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access, and cost. Each component shall be subject to specific accountability measures, including penalties. The Division of Health Benefits may use organizations such as National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI), or any others necessary to develop effective measures for outcomes and quality.

(8) Administrative functions. – PHPs shall be responsible for all administrative functions for recipients enrolled in their plan, including, but not limited to, claims processing, care and case management, grievances and appeals, and other necessary administrative services.

(9) LME/MCOs. – LME/MCOs shall continue to manage the behavioral health services currently covered for their enrollees under all existing waivers, including the 1915(b) and (c) waivers, for four years after the date capitated PHP contracts begin. During this four-year period, the Division of Health Benefits shall continue to negotiate actuarially sound capitation rates directly with the LME/MCOs in the same manner as currently utilized. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits during the four-year period.

SECTION 5. Role of DHHS. – The role and responsibility of DHHS, through the Division of Health Benefits, during Medicaid transformation shall include the following activities and functions:

(1) Submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan amendments necessary to accomplish the requirements of this act within the required time frames.

(2) Define six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation set

forth in Section 1 of this act. Every county in the State must be assigned to a region.

(3) Oversee, monitor, and enforce capitated PHP contract performance.

(4) Ensure sustainability of the transformed Medicaid and NC Health Choice programs.

(5) Set rates, including the following:

a. Capitation rates that are actuarially sound. Actuarial calculations must include utilization assumptions consistent with industry and local standards. Capitation rates shall be risk adjusted and shall include a portion that is at risk for achievement of quality and outcome measures, including value-based payments.

b. Appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees to ensure the achievement of transformation goals.

c. Rates for services in the remaining fee-for-service programs.

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. DHHS, through the Division of Health Benefits, shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by DHHS, through the Division of Health Benefits.

c. Until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS, through the Division of Health Benefits.

d. A requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS pursuant to subdivision (13) of this section, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers.

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

(7) Prior to issuing the RFPs required by subdivision (6) of this section, consult, in accordance with G.S. 12-3(15), with the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the terms and conditions of the requests for proposals (RFPs) for the solicitation of bids for statewide and regional capitated PHP contracts.

(8) Develop and implement a process for recipient assignment to PHPs. Criteria for assignment shall include at least the recipient's family unit, including foster family and adoptive placement, quality measures, and primary care physician.

(9) Define methods to ensure program integrity against provider fraud, waste, and abuse at all levels.

(10) Require all PHPs and Medicaid and NC Health Choice providers to submit data through the Health Information Exchange Network, as required by Section 12A.5 of House Bill 97, 2015 Regular Session, in order to ensure effective systems and connectivity to support clinical coordination of care, the exchange of information, and the availability of data to DHHS and the Division of Health Benefits to manage the Medicaid and NC Health Choice programs for the State.

(11) Develop a Dual Eligibles Advisory Committee, which must include at least a reasonably representative sample of the populations receiving long-term services and supports covered by Medicaid. The Division of Health Benefits, upon the advice of the Dual Eligibles Advisory Committee, shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017.

(12) Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016. At a minimum, this report shall include:

a. The proposed waiver application.

b. The expected time frame for the submission of the proposed waiver to CMS.

c. Proposed statutory changes required.

d. Status of staffing of the Division of Health Benefits, including a description of staff's key competencies and expertise.

e. Anticipated distribution of regional capitated PHP contracts.

f. Plans for recipient enrollment.

g. Recipient access standards.

h. Performance measures.

i. A plan for the proposed inclusion of the following features as part of Medicaid and NC Health Choice transformation:

1. Rate floors in addition to those required by subdivision (5) of Section 5 of this act.

2. Antitrust policies.

3. Protections against the exclusion of certain provider types.

4. Prompt pay requirements.

5. Uniform credentialing requirements.

6. Good-faith negotiations.

j. Time line for issuance of RFP and solicitation of bids.

k. Measures for sustainability of the transformed system.

l. A plan for transition of features of the contract with the North Carolina Community Care Network, Inc., (NCCCN) to the new delivery system, including a plan for utilizing, at the appropriate time, the Health Information Exchange Network to perform certain functions presently being performed by NCCCN's Informatics Center in conjunction with the primary care case management program.

m. A plan to stabilize the Division of Medical Assistance during the transition of the Medicaid and NC Health Choice programs to the Division of Health Benefits.

n. A plan that will ensure continuity of services for individuals in foster care and adoptive placements in the transformed Medicaid and NC Health Choice programs.

(13) Designate Medicaid and NC Health Choice providers as essential providers if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice recipients within the region during the last three years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. DHHS shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

a. Federally qualified health centers.

b. Rural health centers.

c. Free clinics.

d. Local health departments.

SECTION 6. Role of the Department of Insurance. – The transformed Medicaid and NC Health Choice system shall include the licensing of PHPs based on solvency requirements established and implemented by the Department of Insurance. The Commissioner of Insurance, in consultation with the Director of the Division of Health Benefits, shall develop recommended solvency requirements that are similar to the solvency requirements for similarly situated regulated entities and recommended licensing procedures that include an annual review by the Commissioner and reporting of changes in licensure to the Division of Health Benefits. The Commissioner shall report the recommendations as well as proposed fees to offset the cost of licensure and any necessary statutory changes to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016.

SECTION 7. Primary Care Case Management. – By July 1, 2016, DHHS will renegotiate its contract with North Carolina Community Care Networks, Inc., (NCCCN) to reduce per member per month payments to NCCCN for administration, including informatics, by fifteen percent (15%) from the amount of per member per month payments NCCCN received for January 2015. The renegotiated contract shall provide for greater efficiencies and facilitate a smooth transition of features of the enhanced primary care case management program, including case management, informatics center operations, and practice supports, to the primary care medical home model or other care management model that will be utilized by PHPs, consistent with the plan reported to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice pursuant to subdivision (12) of Section 5 of this act. The renegotiated contract shall also include performance measures and consequences for failing to meet those performance measures. DHHS shall continue to utilize NCCCN to perform existing functions until capitated PHP contracts begin as required by this act. When capitated PHP contracts begin, any contract with NCCCN existing on that date shall terminate. Funds equal to the amount of any savings achieved on or after August 1, 2015, by the Division of Medical Assistance as a result of the contract renegotiation required by this section shall be transferred to the Division of Health Benefits to be used for the transition to capitated PHP contracts.

SECTION 8. Innovations Center. – DHHS shall submit a program design and budget proposal no later than May 1, 2016, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice that will create a Medicaid and NC Health Choice Transformation Innovations Center within the Division of Health Benefits with the purpose of

assisting Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. DHHS shall use the Oregon Health Authority's Transformation Center as a design model and shall consider at least the following features:

(1) Learning collaboratives, peer-to-peer networks.
(2) Clinical standards and supports.
(3) Innovator agents.
(4) Council of Clinical Innovators.
(5) Community and stakeholder engagement.
(6) Conferences and workshops.
(7) Technical assistance.
(8) Infrastructure support.

SECTION 9. Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this act, the Department of Health and Human Services, through the Division of Health Benefits created in Section 10 of this act, 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 Division of Health Benefits shall advise the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, created in Section 15 of this act, of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals.

PART II. REORGANIZATION OF MEDICAID AND NC HEALTH CHOICE PROGRAMS

SECTION 10. Creation of the Division of Health Benefits. – The Division of Health Benefits is established as a new division of the Department of Health and Human Services. The Department of Health and Human Services, through the Division of Health Benefits, shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs. The Division of Medical Assistance shall continue to operate the current Medicaid and NC Health Choice programs until the Division of Medical Assistance is eliminated. Upon the elimination of the Division of Medical Assistance, all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance of the Department of Health and Human Services are vested in the Division of Health Benefits. The Department of Health and Human Services shall remain the Medicaid single State agency.

SECTION 11. Elimination of the Division of Medical Assistance. – Twelve months after capitated PHP contracts begin, or at an earlier time as determined by the Secretary of the Department of Health and Human Services, the Division of Medical Assistance and all positions remaining in the Division of Medical Assistance at that time are eliminated. The Secretary shall notify the Office of State Budget and Management and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice three months prior to the date the Secretary anticipates that the Division of Medical Assistance will no longer be needed for future operations of the Medicaid and NC Health Choice programs and will be eliminated. Upon elimination of the Division of Medical Assistance, the Secretary shall notify the Office of

State Budget and Management and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of the effective date of the elimination of the Division of Medical Assistance. The Department of Health and Human Services shall provide notice to employees of the Division of Medical Assistance whose positions will be eliminated due to a reduction in force in accordance with the reduction in force policies of the Office of State Human Resources.

SECTION 12.(a) Article 3 of Chapter 143B of the General Statutes is amended by adding a new part to read:

"Part 36. Division of Health Benefits.

"**§ 143B-216.80. Division of Health Benefits – creation and organization.**

There is hereby established the Division of Health Benefits of the Department of Health and Human Services. The Department of Health and Human Services, through the Division of Health Benefits, shall have the powers and duties described in G.S. 108A-54(e). The Director shall be the head of the Division of Health Benefits."

SECTION 12.(b) Effective January 1, 2021, Part 36 of Article 3 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-216.85. Appointment; term of office; and removal of the Director of the Division of Health Benefits.**

(a) Term. – The Director of the Division of Health Benefits shall be appointed by the Governor for a term of four years subject to confirmation by the General Assembly by joint resolution. The initial term of office for the Director of the Division of Health Benefits shall begin upon confirmation by the General Assembly and shall expire June 30, 2025. Thereafter, the term of office for the Director of the Division of Health Benefits shall be four years and shall commence on July 1 of the year in which the term for which the appointment is made.

(b) Appointment. – The Governor shall submit the name of the person to be appointed Director of the Division of Health Benefits to the General Assembly for confirmation by the General Assembly on or before May 1 of the year in which the term of the office for which the appointment is to be made expires. If the Governor fails to submit a name by May 1, the President Pro Tempore of the Senate and the Speaker of the House of Representatives jointly shall submit a name of an appointee to the General Assembly on or before May 15 of the same year. The appointment shall then be made by enactment of a bill. The bill shall state the name of the person being appointed, the office to which the appointment is being made, the effective date of the appointment, the date of expiration of the term, the residence of the appointee, and that the appointment is made upon the joint recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate. Nothing precludes any member of the General Assembly from proposing an amendment to any bill making such an appointment. If there is no vacancy in the office of the Director, and a bill that would confirm the appointment of the person as Director fails a reading in either chamber of the General Assembly, then the Governor shall submit a new name within 30 days.

(c) Vacancy. – If a vacancy in the office of the Director occurs for any reason prior to the expiration of the Director's term of office, the Governor shall submit the name of the Director's successor to the General Assembly not later than 60 days after the vacancy occurs. If a vacancy occurs when the General Assembly is not in session, the Governor shall appoint an acting Director to serve the remainder of the unexpired term pending confirmation by the General Assembly. However, in no event shall an acting Director serve (i) for more than 12 months without General Assembly confirmation or (ii) after a bill that would confirm the appointment of the person as Director fails a reading in either chamber of the General Assembly. The successor appointed to fill the vacancy shall serve until the end of the unexpired term.

(d) Removal. – The Director of the Division of Health Benefits may be removed from office only by the Governor and solely for the grounds set forth in G.S. 143B-13(b), (c), and (d)."

SECTION 13. G.S. 108A-54 reads as rewritten:

"**§ 108A-54. Authorization of Medical Assistance Program; administration.**

…

(e) The Secretary of the Department of Health and Human Services, through the Division of Health Benefits, shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program. 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 clerical and professional staff of the Division of Health Benefits, including consultants and legal counsel, necessary to carry out the powers and duties of the division. In hiring staff for the Division of Health Benefits, the Secretary may offer employment contracts for a term and set compensation for the employees, which may include performance-based bonuses based on meeting budget or other targets.

(3) Notwithstanding G.S. 143-64.20, 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.

(4) Establish and adjust all program components, except for eligibility categories and income thresholds, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.

(5) Adopt rules related to the Medicaid and NC Health Choice programs.

(6) 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.

(7) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(8) Develop and present to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Office of State Budget and Management by January 1 of each year, beginning in 2017, 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 Department 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.

(9) Publish on its Web site and update on at least a monthly basis, at a minimum, 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.

(f) The General Assembly shall determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs. The Department of Health and Human Services, through the Division of Health Benefits, is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with the parameters set by the General Assembly.

(g) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:

(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.

(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits 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."

SECTION 14.(a) Part 1 of Article 3 of Chapter 143B of the General Statutes is amended by adding the following new section to read:

"**§ 143B-139.6C. Cooling-off period for certain Department employees.**

(a) Ineligible Vendors. – The Secretary of the Department of Health and Human Services shall not contract for goods or services with a vendor that employs or contracts with a person who is a former employee of the Department and uses that person in the administration of a contract with the Department.

(b) Vendor Certification. – The Secretary shall require each vendor submitting a bid or contract to certify that the vendor will not use a former employee of the Department in the administration of a contract with the Department in violation of the provisions of subsection (a) of this section.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. – As used in this section, the following terms mean:

(1) Administration of a contract. – Oversight of the performance of a contract, authority to make decisions regarding a contract, interpretation of a contract, or participation in the development of specifications or terms of a contract or in the preparation or award of a contract.

(2) Former employee of the Department. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Department of Health and Human Services, and in the six months immediately preceding termination of State employment, participated personally in either the award or management of a Department contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor."

SECTION 14.(b) Subsection (a) of this section becomes effective November 1, 2015, and applies to contracts entered into on or after that date.

SECTION 15. Legislative Oversight of Medicaid and NC Health Choice Programs. – Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

"**§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Medicaid and NC Health Choice.**

(a) The Joint Legislative Oversight Committee on Medicaid and NC Health Choice 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, except that initial appointments begin on the date of appointment. 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 Medicaid and NC Health Choice shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs administered by the Department of Health and Human Services.

(b) The Committee may make periodic reports, including recommendations, to a regular session of the General Assembly on issues related to Medicaid and NC Health Choice programs.

"**§ 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 Medicaid and NC Health Choice. The Committee shall meet upon the joint call of the cochairs.

(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.

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

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

Whenever the Department of Health and Human Services, or any division within the Department, is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters relating to the Medicaid and NC Health Choice programs, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice."

SECTION 16. G.S. 120-208.1(a)(2)b. is repealed.

SECTION 17. Jurisdiction for legislative oversight of the Medicaid and NC Health Choice programs is transferred from the Joint Legislative Oversight Committee on Health and Human Services to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. However, both Committees have concurrent jurisdiction over issues related to mental health, developmental disabilities, and substance abuse services covered by the Medicaid and NC Health Choice programs. Any reports related to the Medicaid or NC Health Choice programs shall be provided to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

SECTION 18. 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 Department of Health and Human Services 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, except as provided in G.S. 108A-54(f). For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.

~~(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 ~~Health and Human Services~~ Medicaid and NC Health Choice and the Fiscal Research Division that the amendment has been posted. For any amendments to the State Plan that add or eliminate an optional service, the notice required by this subsection shall be 90 days. This notice 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 Medicaid and NC Health Choice and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."

SECTION 19. G.S. 108A-54.2(d) is repealed.

SECTION 20. G.S. 126-5(c1) is amended by adding new subdivisions to read:

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

…

(c1) Except as to the provisions of Articles 6 and 7 of this Chapter, the provisions of this Chapter shall not apply to:

…

(33) Employees of the Division of Health Benefits of the Department of Health and Human Services.

(34) Employees of the Division of Medical Assistance of the Department of Health and Human Services hired on or after October 1, 2015."

SECTION 21. Funds appropriated in House Bill 97, 2015 Regular Session, to the Department of Health and Human Services, Division of Medical Assistance, for Medicaid transformation shall be used to implement this act. Upon the establishment of a budget code for the Division of Health Benefits, the Division of Medical Assistance shall transfer these funds to the Division of Health Benefits to be used to implement this act.

SECTION 22. If House Bill 97, 2015 Regular Session, becomes law, then Section 12H.25 of that act is repealed.

SECTION 23. Except as otherwise provided, this act is effective when it becomes law.