GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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HOUSE BILL 1181

Committee Substitute Favorable 6/23/14
Committee Substitute #2 Favorable 7/2/14
Senate Rules and Operations of the Senate Committee Substitute Adopted 7/17/14

Short Title: North Carolina Medicaid Modernization. (Public)

Sponsors:

Referred to:

May 22, 2014

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

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

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

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

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

a. In defining regions, the Department of Medical Benefits 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 non-provider-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. Timeline. – The following milestones for Medicaid reform should occur no later than the following dates:

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

SECTION 4. Development of Detailed Plan. – The Department of Medical Benefits 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. 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 Department of Medical Benefits, 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 non-provider-led.

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

(8) Mechanisms for measuring the State's progress towards 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, non-provider-led plans, providers, and the Department of Medical Benefits.

(11) A recommendation of any existing State contracts that should be transferred to the Department of Medical Benefits.

(12) Methods to ensure that the Department of Medical Benefits 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 Department of Medical Benefits 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) transfer existing data and resources at the Department of Health and Human Services to the Department of Medical Benefits, (ii) monitor performance of health plans, and (iii) provide information to and receive information from service providers.

(15) Plans to interact with other State agencies in areas such as communications with the Centers for Medicare & Medicaid Services (CMS) prior to becoming the single State entity, eligibility determinations, the allocation of Medicaid-related costs to the Medicaid program, the interaction of the new Medicaid program with other State information technology systems, and other issues that will require coordination with other State agencies.

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

(17) 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 March 1, 2015, the Department of Medical Benefits shall report to the General Assembly the Department's strategic plan for the Medicaid reform required under Section 4 of this act. If a detailed plan cannot reasonably be completed by March 1, 2015, the Department of Medical Benefits shall (i) inform the report recipients by February 1 that the March 1 report will be a progress report and (ii) provide by March 1 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, 2015, and every six months thereafter until a final report on September 1, 2020, the Department of Medical Benefits 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 Medical Benefits.

SECTION 7. Maintain Funding Mechanisms. – In developing its detailed plan under Section 4 of this act, the Department of Medical Benefits 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. This work with CMS shall be facilitated by the Department of Health and Human Services, Division of Medical Assistance, as required by subsection (a) of Section 8 of this act. If such Medicaid-specific funding cannot be maintained as currently implemented, then the Division 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 Department of Medical Benefits 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. DHHS Role in Reform. – (a) During the time of transition of the Medicaid program into its new form, the Department of Health and Human Services, Division of Medical Assistance, shall cooperate with the Department of Medical Benefits to ensure a smooth transition of the Medicaid program, as well as the NC Health Choice program. The Division shall facilitate communications between the Department of Medical Benefits and the Centers for Medicare & Medicaid Services (CMS) and shall submit State plan amendments (SPAs) as requested by the Department of Medical Benefits. The Department of Health and Human Services shall cease any activities related to implementing Medicaid reform within the existing Division of Medical Assistance, except for activities directly related to assisting the new Department of Medical Benefits in the reform process. The Department of Medical Benefits and the Department of Health and Human Services shall enter into appropriate memoranda of understanding (MOUs) to define the responsibilities of each entity during the Medicaid reform process.

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

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

(2) Work with the Department of Medical Benefits during the transition, as required by subsection (a) of this section.

(3) Develop strategies to successfully complete the requirements of subdivisions (1) and (2) of this subsection.

(4) Make recommendations to the Joint Legislative Oversight Committee on Medical Benefits on any additional authorization or funding necessary to successfully complete the requirements of subdivisions (1) and (2) of this subsection.

(5) With assistance from the Office of State Human Resources, conduct interviews and meetings with designated essential employees of the Division of Medical Assistance to explain the transition process, including options for the employees and the bonus payment system established under subsection (c) of this section.

(6) No later than September 1, 2014, report to the Joint Legislative Oversight Committee on Medical Benefits on the plan to communicate to employees, as required by subdivision (5) of this subsection.

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

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

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

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

(1) Effective August 1, 2014, any employee working in a designated essential position within the Division of Medical Assistance shall receive a bonus at each pay period that is equal to five percent (5%) of the employee's earnings for that period.

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

(3) Any employee who received bonus payments under subdivision (1) of this subsection who is still employed within the Division of Medical Assistance

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

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

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

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

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

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

…

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

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

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

"Article 14.

"Department of Medical Benefits.

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

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

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

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

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

(1) Three appointments by the Governor as follows:

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

b. One individual with expertise in public assistance programs.

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

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

a. One individual with expertise in managed care.

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

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

a. One individual with expertise in health insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) 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.

(h) Board members are not State employees.

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

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

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

(1) 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 Department, and other staff, including legal staff. In hiring staff, the Board may offer employment contracts for a term.

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

(4) Procure office space for the Department.

(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.

(6) Form committees of the Board.

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

a. Business policy.

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

c. Program and policy changes.

d. Operational budget and assumptions.

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

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

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

a. A detailed five-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 year's forecasted enrollment growth and enrollment mix.

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

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

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

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

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

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

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

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

(1) Employees of the Department shall not be subject to portions of the State Personnel Act, as provided in G.S. 126-5(c13). After July 1, 2016, however, the Department 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 Department may choose to retain legal counsel other than the Attorney General.

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

(4) If the Department establishes alternative procedures for the review and approval of contracts, then the Department 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.

(5) The Board 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. Per member per month rates or other rates paid to health plans.

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

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

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

(6) 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 (5) of this subsection, 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, findings from an audit or investigation, the annual budget forecast report, or a report to the General Assembly."

SECTION 10.(b) 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 Department of Medical Benefits, except for employees designated by the Board as subject to this Chapter under G.S. 143B-1415(a)."

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

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

SECTION 12. 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 Medical Benefits.

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

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

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

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

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

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

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

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

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

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

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

"**§ 120-209.3. Additional powers.**

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

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

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

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

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

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

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