GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 372
Committee Substitute Favorable 6/11/15
Committee Substitute #2 Favorable 6/18/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H372-PCS20391-TR-4

Short Title: Medicaid Transformation/HIE/PrimaryCare/Funds. (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, TO PROVIDE FUNDS FOR THE OVERSIGHT AND ADMINISTRATION OF THE STATEWIDE HEALTH INFORMATION EXCHANGE NETWORK, TO INCREASE MEDICAID RATES TO PRIMARY CARE PHYSICIANS, AND TO DISCONTINUE MEDICAID PRIMARY CARE CASE MANAGEMENT.

The General Assembly of North Carolina enacts:

MEDICAID TRANSFORMATION AND REORGANIZATION

SECTION 1.(a) Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid program to a program 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) 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 1.(b) Structure of Delivery System. – The transformed Medicaid program described in subsection (a) of this section shall be organized according to the following principles and parameters:

(1) The Department of Medicaid (DOM), created in subsection (h) of this section, shall have full budget and regulatory authority to manage the State's Medicaid and NC Health Choice programs, except the General Assembly shall determine eligibility categories and income thresholds.
(2) Among its initial tasks, the DOM shall:
    a. Determine the structural and financial qualifications required for Medicaid managed care organizations (MCOs), which is defined to include both commercial insurers and provider-led entities (PLEs). A PLE is defined as any of the following: a provider; an entity with the primary purpose of owning or operating one or more providers; or a business entity in which providers hold a controlling ownership interest. The majority of the members of a PLE's governing board

shall be composed of providers as defined in G.S. 108C-2 or entities composed of providers.

b. Designate at least five and no more than eight regions within the State. Regions must be composed of whole, contiguous counties, and every county in the State must be assigned to a region.

(3) The DOM shall enter into contractual relationships with commercial insurers and PLEs for the delivery of all Medicaid health care items and services. All contracts shall be the result of a request for proposals (RFP) issued by the DOM and the submission of competitive bids by commercial insurers and PLEs. The governing principles and minimum terms and conditions of the RFPs, bids, and contracts are described in subsection (d) of this section.

(4) The number and nature of the contracts required under subdivision (3) of this subsection shall be as follows:

a. Three contracts between the DOM and any combination of individual commercial insurers and individual PLEs. Each of these contracts shall provide statewide coverage for all Medicaid health care items and services (statewide contracts).

b. Up to 12 contracts between the DOM and individual PLEs for coverage of specified regions (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 all Medicaid health care items and services. A PLE may bid on more than one region. The DOM shall have full discretion to enter into one, two, or no regional contracts in any region.

(5) As a result of the contracts entered into by the DOM under subdivision (3) of this subsection, a recipient shall have at least three, but no more than five enrollment choices for the provision of all Medicaid health care items and services. The DOM shall provide for annual open enrollment periods and shall determine the process for assigning recipients who do not select a commercial insurer or PLE during the enrollment period.

SECTION 1.(c) Time Line. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. –

a. The Department of Medicaid is created pursuant to subsection (h) of this section.

b. The Joint Legislative Oversight Committee on Medicaid (LOC on Medicaid) is created pursuant to subsection (l) of this section to oversee the Medicaid and NC Health Choice programs.

(2) December 1, 2015. – The Department of Health and Human Services (DHHS) shall establish the Medicaid stabilization team pursuant to subsection (g) of this section.

(3) January 1, 2016. –

a. The DOM is designated as the single State agency for the administration of Medicaid and NC Health Choice.

b. The DHHS and the DOM shall enter into agreements necessary for the DOM to supervise the DHHS's administration of the Medicaid and NC Health Choice programs.

(4) May 1, 2016. –

a. The DOM shall submit requests for waivers and State Plan amendments to the Centers for Medicare and Medicaid Services (CMS) necessary to implement Medicaid transformation.
b. The DOM shall report recommended statutory changes to the North Carolina General Statutes to the LOC on Medicaid.

(5) Twelve months after CMS approval of all necessary waivers and State Plan amendments. – Capitated full-risk contracts begin.

SECTION 1.(d) Requests for Proposals; Bids; Terms and Conditions of Contracts. – The following shall be components of the initial RFPs, responsive bids to the initial RFPs, and the initial contracts that are required under subsection (b) of this section.

(1) An RFP may solicit bids for a statewide contract, a regional contract, or both and may propose variable contract durations.

(2) RFPs must require at least all of the following:
a. Full-risk capitation for all Medicaid health care items and services.
b. Coverage for all program aid categories except the dual eligible categories.
c. All bidders meet solvency requirements established by the Department of Insurance pursuant to subsection (k1) of this section.
d. All bidders meet the same standards and metrics for risk, outcomes, and quality.
e. All bidders establish appropriate networks of providers to deliver services.
f. All bidders subcontract with existing LME/MCOs for behavioral health services through the end date of the first contract entered into pursuant to this subsection at a capitation rate that is no less than the most recently negotiated rate for the then current scope of benefits paid to LME/MCOs.
g. All bidders agree not to limit providers' ability to contract with other commercial insurers and PLEs.
h. All bidders must connect to the Health Information Exchange Network or any successor information technology entity or architecture specified by the DOM in order to ensure effective systems and connectivity to support clinical coordination of care, exchange of information, and the availability of data to the DOM to manage the Medicaid and NC Health Choice program for the State.
i. All bidders ensure that their contracts with providers include value-based payment systems that support the achievement of overall performance, quality, and outcome measures.

(3) All bids must respond to the requirements of subdivision (2) of this subsection and must also include at least all of the following:
a. For statewide contracts, a description of how the commercial insurer or PLE will ensure access to appropriate care throughout the State.
b. For regional contracts, a description of how the PLE will ensure access to appropriate care throughout the region.
c. Proposed competitive medical loss ratios.
d. Proposed full-risk capitated rates based on Centers for Medicare and Medicaid Services (CMS) actuarial soundness and industry standards as well as risk-adjusted rate ranges using claims data from fiscal year 2014-2015. Actuarial calculations must include utilization assumptions consistent with industry and local standards.

e. Methods to ensure program integrity against provider fraud, waste, and abuse at all levels.

(4) In addition to the requirements of subdivisions (1) through (3) of this subsection, each contract must provide for all of the following:

a. Negotiated full-risk capitated rates, including a portion that is at risk for achievement of quality and outcome measures.

b. Negotiated competitive medical loss ratios.

c. Compliance by the commercial insurer or PLE with all CMS requirements for the Medicaid and NC Health Choice programs.

d. Defined measures and goals for risk adjusted health outcomes, quality of care, patient satisfaction, access, and cost. Each component must be measured and monitored continually and reported at set intervals as determined by the DOM. Each component shall be subject to specific accountability measures, including penalties. The DOM may use organizations such as National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI), Healthcare Effectiveness Data and Information Set (HEDIS), or any others necessary to develop effective measures for outcomes and quality.

e. Acceptance of full responsibility by the commercial insurer or PLE for all grievance and appeals.

f. Ability of the commercial insurer or PLE to exclude providers from networks based on economic or quality standards.

g. Ability of the commercial insurer or PLE to terminate the capitation rate required under sub-subdivision f. of subdivision (2) of this subsection if termination of the rate is mutually agreed to by the LME/MCO.

h. Agreement that covered benefits will not be reduced from the covered services in effect on the date the contract is awarded except in instances where the DOM reduces a covered service for all recipients and for all contracts.

i. A rate floor for primary care and specialty care services set by the DOM to ensure recipients have appropriate access to these services.

j. Agreement that the commercial insurer or PLE will pay LME/MCOs the capitation rate required by sub-subdivision f. of subdivision (2) of this subsection within 30 days after the commercial insurer or PLE receives funds for the capitation from the DOM.

k. A requirement that the commercial insurer or PLE must keep the cost growth for its enrollees 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.

l. A requirement that the commercial insurer or PLE participate in the existing preferred drug list program maintained by DHHS as required by Section 10.66 of S.L. 2009-451 and maximize the recovery and collection of drug rebates.

SECTION 1.(e) Monthly Progress Report. – Beginning February 1, 2016, and monthly thereafter until January 1, 2019, the DOM shall report to the LOC on Medicaid and the Fiscal Research Division on the State's progress toward completing Medicaid transformation. The May 1, 2016, report shall contain proposed changes to the North Carolina General Statutes that are necessary to implement Medicaid transformation.

SECTION 1.(f) Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this section, the DOM shall work with the Centers for Medicare and 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 DOM shall advise the LOC on Medicaid created in subsection (l) of this section 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.

SECTION 1.(g) DHHS Role in Medicaid Transformation. – During Medicaid transformation, the Department of Health and Human Services, Division of Medical Assistance (DMA), shall cooperate with the DOM to ensure a smooth transition of the Medicaid and NC Health Choice programs and shall perform all of the following functions:

(1) The DHHS and the DOM shall enter into agreements necessary for the DOM to supervise the DHHS's administration of the Medicaid and NC Health Choice programs until the transformed Medicaid program is completed.

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

a. Maintain the Medicaid and NC Health Choice programs until Medicaid transformation has been completed.

b. Work with the DOM during the transition.

c. Develop strategies to successfully complete the requirements of sub-subdivisions a. and b. of this subdivision.

d. Make recommendations to the LOC on Medicaid on any additional authorization or funding necessary to successfully complete the requirements of sub-subdivisions a. and b. of this subdivision.

e. With assistance from the Office of State Human Resources, conduct interviews and meetings with designated essential employees of the DMA to explain the transition process, including options for the employees and the bonus payment system established under this subsection.

f. No later than December 1, 2015, report to the LOC on Medicaid on the plan to communicate to employees, as required by sub-subdivision e. of this subdivision.

(3) The Office of the Secretary shall identify the key managers, leaders, and decision makers to be part of the stabilization team and, no later than December 1, 2015, shall submit a list of these people and their roles to the DOM and the LOC on Medicaid.

(4) No later than December 1, 2015, the Secretary of Health and Human Services (Secretary) shall identify and designate "essential positions" throughout the DHHS without which the Medicaid and NC Health Choice programs could not operate on a day-to-day basis. Such positions designated by the Secretary may include any position, whether subject to or exempt from the North Carolina Human Resources 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 subsection, the designation of a position as essential may not be revoked, and the Secretary may designate both open and filled positions.

(5) In order to encourage employees to remain in their positions working on Medicaid and NC Health Choice within the DHHS, employees serving in positions designated as essential positions under this subsection shall be eligible for the following benefits:

a. Effective November 1, 2015, any employee working in a designated essential position within the DMA shall receive a bonus at each pay period that is equal to five percent (5%) of the employee's earnings for that period.

b. Effective November 1, 2015, any employee working in a designated essential position within the DHHS, but outside of the DMA, 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 sub-subdivision a. of this subdivision. If such an employee working outside of the DMA 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%).

c. Any employee who received bonus payments under sub-subdivisions a. or b. of this subdivision who is still employed within the DMA or within the DHHS as of October 31, 2017, or who is employed within the DOM, shall receive a final bonus payment equal to the sum of all the bonus payments that the employee had received since November 1, 2015, under sub-subdivision a. of this subdivision. No employee departing before October 31, 2017, shall be eligible to receive any portion of such a final bonus payment, and no property right is created by this subsection for employees that depart before October 31, 2017.

d. The bonus payments paid under this subsection 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 subsection shall not count as "compensation" for purposes of the Retirement System for Teachers and State Employees, nor shall the DHHS be required to make payments to the Retirement System based on the amounts paid as bonuses. Additionally, bonus payments paid under this subsection shall not count as "compensation" or "salary" for calculating severance payments under G.S. 126-8.5 or calculating unemployment benefits.

(6) The DHHS shall not enter into any new contracts, or renew or extend any contracts that existed prior to the effective date of this subsection, related to the Medicaid or NC Health Choice programs without the express prior approval of the DOM. The DHHS and the DMA 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 DHHS or the DMA to terminate the contract without cause upon 30 days' notice. Any contract signed by the DHHS or the DMA 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 1.(h) The Department of Medicaid is established as a new executive department. In accordance with the time line set out in subsection (c) of this section, the Department of Medicaid shall administer and operate all functions, powers, duties, obligations, and services related to the Medicaid and NC Health Choice programs. In accordance with the time line set out in subsection (c) of this section, 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 Department of Medicaid.

SECTION 1.(i) Chapter 143B of the General Statutes is amended by adding a new Article to read:

"Article 14.

"Department of Medicaid.

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

(a) There is hereby established the Department of Medicaid (Department) to administer and operate the Medicaid and NC Health Choice programs. The head of the Department of Medicaid is the Secretary of the Department of Medicaid, who shall be known as the Secretary. The Department shall be the designated single State agency for the administration and operation of the Medicaid and NC Health Choice programs.

(b) The Secretary shall be appointed by the Governor subject to confirmation by the General Assembly by joint resolution, which shall originate in the House of Representatives. The Secretary shall be subject to removal by the Governor.

(c) The powers and duties of the deputy secretaries and the divisions and directors of the Department shall be subject to the direction and control of the Secretary.

"**§ 143B-1405. Powers and duties of the Secretary of Medicaid.**

(a) The Secretary of the Department of Medicaid 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) Appoint all employees, including consultants and legal counsel, necessary to carry out the powers and duties of the office. In hiring staff, the Secretary may offer employment contracts for a term and set compensation for the employees, including performance-based bonuses based on meeting budget or other targets.

(3) Procure office space for the Department.

(4) 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.

(5) Employ or contract for independent internal auditing staff.

(6) 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 Secretary may enter into a Memorandum of Understanding with the Department of Health and Human Services or contract with any other appropriate party to perform this task or a portion of this task.

(7) Define and implement the following for the Medicaid and Health Choice programs and any other programs administered by the Department:

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 Department's strengths and weaknesses to address these opportunities and challenges.
4. Identify key goals for the Department for this time period, consistent with the reform goals identified by the General Assembly.
5. Identify output and outcome performance measures to quantify the Department's progress toward these goals.
6. Identify strategies to reach these goals.
7. Be used as a guide for units within the Department 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 Department 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 Department 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.

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

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

(10) 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.

(11) 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.

(12) Develop and present to the Joint Legislative Oversight Committee on Medicaid 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.

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

(14) Publish the Annual Medicaid Report, which shall contain, at a minimum, the following:

a. Details on the Department'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.

(15) 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) Pursuant to G.S. 108E-2-1, the General Assembly retains the authority to determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs.

"**§ 143B-1410. 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 Medicaid and the Secretary of the Department of Medicaid, notwithstanding any other provision of law:

(1) Employees of the Department 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 Department's employment contracts offered pursuant to G.S. 143B-1405(a)(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 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.

"**§ 143B-1415. Cooling-off period for certain Department employees.**

(a) Ineligible Vendors. – The Secretary of the Department of Medicaid shall not contract for goods or services with a vendor that employs or contracts with a person who is a

former Medicaid or NC Health Choice employee 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 Medicaid or NC Health Choice employee in the administration of a contract with the Department in violation of the provisions of subsection (a) of this section. Any person who submits a certification required by this subsection knowing the certification to be false shall be guilty of a Class I felony.

(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 Medicaid or NC Health Choice employee. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Department, 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.

"**§ 143B-1420. 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-1410(a)(10).

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

(1) Minimum target. – Five percent (5%) of a given fiscal year's General Fund appropriations for capitation payments for both the Medicaid and NC Health Choice programs.

(2) Maximum target. – Twelve percent (12%) of a given fiscal year's General Fund appropriations for capitation payments for both the Medicaid and NC Health Choice programs.

(c) Notwithstanding G.S. 143C-1-2(b), any funds appropriated to the Department 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) Medicaid Reserve Account funds may be disbursed by the Secretary to manage budgetary shortfalls in the Medicaid and NC Health Choice programs only after all of the following occur:

(1) The Secretary certifies that there is a projected Medicaid shortfall in the current fiscal year.

(2) The Secretary has already made midyear budget corrections under G.S. 143B-1410(a)(10), but those midyear budget corrections have not achieved the projected budget savings.

(3) The Secretary reports to the Joint Legislative Commission on Governmental Operations on its intent to disburse Medicaid Reserve Account funds. 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.

(e) Medicaid Reserve Account funds may be disbursed in accordance with subsection (d) of this section even if it results in the fund balance falling below the minimum target balance for the Medicaid Reserve Account."

SECTION 1.(j) Transfer of Rules. – Effective January 1, 2016, all rules and policies exempted from rule making related to the Medicaid and NC Health Choice programs shall transfer to the Department of Medicaid. In its May 1, 2016, report to the Joint Legislative Oversight Committee on Medicaid, the Department shall include recommendations for additional exemptions from the rule-making requirements and contested case provisions in Chapter 150B of the General Statutes.

SECTION 1.(k) Legal Actions. – 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 Department of Medicaid 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 1.(k1) The Commissioner of Insurance shall establish solvency requirements for MCOs and PLEs that contract with the Department pursuant to this section. The same requirements shall apply to and may be based on existing requirements for similarly situated regulated entities. The Commissioner shall consult with the Secretary of the Department of Medicaid in developing the requirements. The Commissioner shall make recommendations, including any statutory changes, to the Joint Legislative Oversight Committee on Medicaid by May 1, 2016.

SECTION 1.(l) Legislative Oversight of Medicaid. – Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on Medicaid.

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

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

(b) The Committee may make periodic reports to the General Assembly on matters for which it may report to a regular session of the General Assembly.

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

SECTION 1.(m) G.S. 120-208.1(a)(2)b. is repealed.

SECTION 1.(n) Recodification; Technical and Conforming Changes. – 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 Department of Medicaid and references to the Secretary of the Department of Health and Human Services to the Secretary of the Department of Medicaid. 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 Department of Medicaid." The Revisor of Statutes may conform names and titles changed by this subsection, and may correct statutory references as required by this subsection, throughout the General Statutes. In making the changes authorized by this subsection, the Revisor may also adjust subject and verb agreement and the placement of conjunctions. The Revisor shall consult with the Department of Health and Human Services and the Department of Medicaid on this recodification.

SECTION 1.(o) 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 ~~Department of Health and Human Services~~Department of Medicaid"

SECTION 1.(p) 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 Medicaid 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 1.(q) G.S. 108A-54.2(d) is repealed.

SECTION 1.(r) Part 1 of Article 2 of Chapter 108E of the General Statutes, created by the recodification process described in subsection (n) 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 Department of Medicaid shall not alter the eligibility categories and income thresholds from

those authorized by the General Assembly. The Department 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 1.(s) G.S. 126-5(c1) is amended by adding a new subdivision 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:

…

(31) Employees of the Department of Medicaid."

SECTION 1.(t) 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 ~~Department of Health and Human Services~~Department of Medicaid 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 1.(u) 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 ~~Department of Health and Human Services~~ Department of Medicaid 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 ~~Department of Health and Human Services~~ Department of Medicaid in implementing, operating, or overseeing new 1915(b)/(c) Medicaid Waiver programs or amendments to existing 1915(b)/(c) Medicaid Waiver programs.

…

(22) The ~~Department of Health and Human Services~~ Department of Medicaid 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 ~~Department of Health and Human Services~~ Department of Medicaid 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 1.(v) Appropriation. – The sum of five million dollars ($5,000,000) in recurring funds for the 2015-2016 and the 2016-2017 fiscal years are appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, to accomplish the Medicaid transformation required by this section. These funds shall provide a State match for an estimated five million dollars ($5,000,000) in federal funds beginning in the 2015-2016 fiscal year. Upon request of the Department of Medicaid, but no later than January 1, 2016, the Department shall transfer these funds to the Department of Medicaid to be used for Medicaid transformation.

SECTION 1.(w) Effective Date. – Subsections (n) through (u) of this section become effective January 1, 2016. The remainder of this section is effective when this act becomes law.

FUNDS FOR OVERSIGHT AND ADMINISTRATION OF STATEWIDE HEALTH INFORMATION EXCHANGE NETWORK

SECTION 2.(a) It is the intent of the General Assembly to do all of the following with respect to health information exchange:

(1) Establish a successor HIE Network to which (i) all Medicaid providers shall be connected by October 1, 2017, and (ii) all other entities that receive State funds for the provision of health services shall be connected by January 1, 2018.

(2) Establish (i) a State-controlled Health Information Exchange Authority to oversee and administer the successor HIE Network and (ii) a Health Information Exchange Advisory Board to provide consultation to the Authority on matters pertaining to administration and operation of the HIE Network and on statewide health information exchange, generally.

(3) Have the successor HIE Network gradually become and remain one hundred percent (100%) receipt-supported by establishing reasonable participation fees approved by the General Assembly and by drawing down available matching funds whenever possible.

SECTION 2.(b) In order to achieve the objectives described in subsection (a) of this section, the sum of eight million dollars ($8,000,000) in recurring funds is appropriated to the Department of Health and Human Services, Division of Central Management and Support, for the 2015-2016 fiscal year and for the 2016-2017 fiscal year to continue efforts toward the implementation of a statewide health information exchange network. These funds shall be transferred to the Office of Information Technology Services. By 30 days after the effective date of this section, the Secretary of the Department of Health and Human Services and the State Chief Information Officer (State CIO) shall enter into a written memorandum of understanding pursuant to which the State CIO will have sole authority to direct the expenditure of these funds until (i) the North Carolina Health Information Exchange Authority (Authority) is established and the State CIO has appointed an Authority Director and (ii) the North Carolina Health Information Exchange Advisory Board (Advisory Board) is established with members appointed pursuant to Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section. The State CIO shall use these transferred funds to accomplish the following:

(1) Beginning immediately upon receipt of the transferred funds, facilitate the following:

a. Establishment of the successor HIE Network described in subsection (a) of this section.

b. Termination or assignment to the Authority by December 31, 2015, of any contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

(2) Fund the monthly operational expenses incurred or encumbered by the NC HIE from July 1, 2015, until December 31, 2015. Notwithstanding any other provision of law to the contrary, the total amount of monthly operating expenses paid for with these funds shall not exceed one hundred seventy-seven thousand dollars ($177,000) per month or a total of one million sixty-two thousand dollars ($1,062,000) for the six-month period commencing July 1, 2015, and ending December 31, 2015. The State CIO shall terminate payments for these monthly operational expenses upon the earlier of December 31, 2015, or upon the termination or assignment to the Authority of all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

The State CIO is encouraged to explore all available opportunities for the State to receive federal grant funds and federal matching funds for health information exchange.

SECTION 2.(c) Once the Authority Director has been hired and the Advisory Board has been established with members appointed pursuant to Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section, the Authority shall use these funds to do the following:

(1) Fund the operational expenses of the Authority and the Advisory Board.

(2) Establish, oversee, administer, and provide ongoing support of a successor HIE Network to the HIE Network established under Article 29A of Chapter 90 of the General Statutes.

(3) Enter into any contracts necessary for the establishment, administration, and operation of the successor HIE Network.

(4) Facilitate the termination or assignment to the Authority by December 31, 2015, of any contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

(5) Fund the monthly operational expenses incurred or encumbered by the NC HIE from July 1, 2015, until December 31, 2015. Notwithstanding any other provision of law to the contrary, the total amount of monthly operating expenses paid for with these funds shall not exceed one hundred seventy-seven thousand dollars ($177,000) per month or a total of one million sixty-two thousand dollars ($1,062,000) for the six-month period commencing July 1, 2015, and ending December 31, 2015. The Authority shall terminate payments for these monthly operational expenses upon the earlier of December 31, 2015, or upon the termination or assignment to the Authority of all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

The Authority is encouraged to explore all available opportunities for the State to receive federal grant funds and federal matching funds for health information exchange.

SECTION 2.(d) Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 29B.

"Statewide Health Information Exchange Act.

"**§ 90-414.1. Title.**

This act shall be known and may be cited as the "Statewide Health Information Exchange Act."

"**§ 90-414.2. Purpose.**

This Article is intended to improve the quality of health care delivery within this State by facilitating and regulating the use of a voluntary, statewide health information exchange network for the secure electronic transmission of individually identifiable health information among health care providers, health plans, and health care clearinghouses in a manner that is consistent with the Health Insurance Portability and Accountability Act, Privacy Rule and Security Rule, 45 C.F.R. §§ 160, 164.

"**§ 90-414.3. Definitions.**

The following definitions apply in this Article:

(1) Business associate. – As defined in 45 C.F.R. § 160.103.

(2) Business associate contract. – The documentation required by 45 C.F.R. § 164.502(e)(2) that meets the applicable requirements of 45 C.F.R. § 164.504(e).

(3) Covered entity. – Any entity described in 45 C.F.R. § 160.103 or any other facility or practitioner licensed by the State to provide health care services.

(4) Disclose or disclosure. – The release, transfer, provision of access to, or divulging in any other manner an individual's protected health information through the HIE Network.

(5) Emergency medical condition. – A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (i) placing an individual's health in serious jeopardy, (ii) serious impairment of an individual's bodily functions, or (iii) serious dysfunction of any bodily organ or part of an individual.

(6) GDAC. – The North Carolina Government Data Analytics Center.

(7) Health Benefits Authority. – The Authority established under Article 14 of Chapter 143B of the General Statutes to operate the Medicaid and NC Health Choice programs.

(8) HIE Network. – The voluntary, statewide health information exchange network overseen and administered by the Authority.

(9) HIPAA. – The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended.

(10) Individual. – As defined in 45 C.F.R. § 160.103.

(11) North Carolina Health Information Exchange Advisory Board or Advisory Board. – The Advisory Board established under G.S. 90-414.6.

(12) North Carolina Health Information Exchange Authority or Authority. – The entity established pursuant to G.S. 90-414.5.

(13) Opt out. – An individual's affirmative decision to disallow his or her protected health information maintained by or on behalf of one or more specific covered entities from being disclosed to other covered entities through the HIE Network.

(14) Protected health information. – As defined in 45 C.F.R. § 160.103.

(15) Public health purposes. – The public health activities and purposes described in 45 C.F.R. § 164.512(b).

(16) Qualified organization. – An entity designated by the Authority to contract with covered entities on behalf of the Authority to facilitate the participation of such covered entities in the HIE Network.

(17) Research purposes. – Research that meets the standard described in 45 C.F.R. § 164.512(i).

(18) State CIO. – The State Chief Information Officer.

"**§ 90-414.4. Required participation in HIE Network for some providers.**

(a) The General Assembly makes the following findings:

(1) That controlling escalating health care costs of the Medicaid program and other State-funded health services is of significant importance to the State, its taxpayers, its Medicaid recipients, and other recipients of State-funded health services.

(2) That the Health Benefits Authority needs timely access to claims and clinical information in order to assess performance, improve health care outcomes, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending money on Medicaid and other State-funded health services.

(3) That making this clinical information available through the HIE Network will improve care coordination within and across health systems, increase care quality, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health care cost containment.

(b) As a condition of receiving State funds, including Medicaid funds, the following entities shall connect to the HIE Network and submit individual patient demographic and clinical data on services paid for with State funds, including Medicaid funds, based on the findings set forth in subsection (a) of this section and notwithstanding the voluntary nature of the HIE Network under G.S. 90-414.2:

(1) Each hospital, as defined in G.S. 131E-76(3), that has an electronic health record system.

(2) Each Medicaid provider.

(3) Each provider that receives State funds for the provision of health services.

(c) The Authority shall give the Health Benefits Authority real-time access to data and information disclosed through the HIE Network. At the request of the Director of the Fiscal Research, Bill Drafting, Research, or Program Evaluation Division of the General Assembly for data and information disclosed through the HIE Network or for a consolidation or analysis of the data and information disclosed through the HIE Network, the Authority shall provide the professional staff of these Divisions with data and information responsive to the Director's request. Prior to providing the General Assembly's staff with any data or information disclosed through the HIE Network or with any compilation or analysis of data or information disclosed through the HIE Network, the Authority shall redact any personal identifying information in a manner consistent with the standards specified for de-identification of health information under the HIPAA Privacy Rule, 45 C.F.R. § 164.15, as amended.

"**§ 90-414.4A. State ownership of data disclosed through HIE Network.**

Any data disclosed through the HIE Network pursuant to G.S. 90-414.4 or any other provision of this Article shall be and will remain the sole property of the State. Any data or product derived from the data disclosed to the HIE Network pursuant to G.S. 90-414.4 or any other provision of this Article, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The Authority shall not allow proprietary information it receives pursuant to G.S. 90-414.4 or any other provision of this Article to be used by any person or entity for commercial purposes.

"**§ 90-414.5. North Carolina Health Information Exchange Authority.**

(a) Creation. – There is hereby established the North Carolina Health Information Exchange Authority to oversee and administer the HIE Network in accordance with this Article. The Authority shall be located within the Office of Information Technology Services and shall be under the supervision, direction, and control of the State CIO. The State CIO shall employ an Authority Director and may delegate to the Authority Director all powers and duties associated with the daily operation of the Authority, its staff, and the performance of the powers and duties set forth in subsection (b) of this section. In making this delegation, however, the State CIO maintains the responsibility for the performance of these powers and duties.

(b) Powers and Duties. – The Authority has the following powers and duties:

(1) Oversee and administer the HIE Network in a manner that ensures all of the following:

a. Compliance with this Article.

b. Compliance with HIPAA and any rules adopted under HIPAA, including the Privacy Rule and Security Rule.

c. Compliance with the terms of any business associate contract the Authority or qualified organization enters into with a covered entity participating in the HIE Network.

d. Notice to the patient by the provider on the initial visit about the HIE Network, including information and education about the right of individuals on a continuing basis to opt out or rescind a decision to opt out.

e. Opportunity for all individuals to exercise on a continuing basis the right to opt out or rescind a decision to opt out.

f. Nondiscriminatory treatment by covered entities of individuals who exercise the right to opt out.

(2) Employ staff necessary to carry out the provisions of this Article and determine the compensation, duties, and other terms and conditions of employment of hired staff.

(3) Enter into contracts pertaining to the oversight and administration of the HIE Network, including contracts of a consulting or advisory nature. G.S. 143-64.20 does not apply to this subdivision.

(4) Establish fees approved by the General Assembly for participation in the HIE Network.

(5) Following consultation with the Advisory Board, develop and enter into written participation agreements with covered entities that utilize the HIE Network. The participation agreements shall specify the terms and conditions governing participation in the HIE Network. The agreement shall also require compliance with policies developed by the Authority pursuant to this Article or pursuant to applicable laws of the state of residence for entities located outside of North Carolina. In lieu of entering into a participation agreement directly with covered entities, the Authority may enter into participation agreements with qualified organizations, which in turn enter into participation agreements with covered entities.

(6) Add, remove, disclose, and access protected health information through the HIE Network in accordance with this Article.

(7) Following consultation with the Advisory Board, enter into a business associate contract with each of the covered entities participating in the HIE Network. In lieu of entering into a business associate contract directly with covered entities, the Authority may enter into business associate contracts

with qualified organizations, which in turn may enter into business associate contracts with covered entities.

(8) Following consultation with the Advisory Board, grant user rights to the HIE Network to business associates of covered entities participating in the HIE Network (i) at the request of the covered entities and (ii) at the discretion of the Authority upon consideration of the business associates' legitimate need for utilizing the HIE Network and privacy and security concerns.

(9) Facilitate and promote use of the HIE Network by covered entities.

(10) Periodically monitor compliance with this Article by covered entities participating in the HIE Network.

(11) Collect clinical health data from all Medicaid providers and other providers that receive State funds for the provision of health services in order to ensure the efficient delivery of Medicaid and other health services and to improve patient outcomes and measure performance.

(12) Collaborate with the State CIO to ensure that resources available through the GDAC are properly leveraged, assigned, or deployed to support the work of the Authority. The duty to collaborate under this subdivision includes collaboration on data hosting and development, implementation, operation, and maintenance of the HIE Network.

(13) Initiate or direct expansion of existing public-private partnerships within the GDAC as necessary to meet the requirements, duties, and obligations of the Authority. Notwithstanding any other provision of law and subject to the availability of funds, the State CIO, at the request of the Authority, shall assist and facilitate expansion of existing contracts related to the HIE Network, provided that such request is made in writing by the Authority to the State CIO with reference to specific requirements set forth in this Article.

(14) In consultation with the Advisory Board, develop a strategic plan for achieving statewide participation in the HIE Network by all hospitals and health care providers licensed in this State.

(15) In consultation with the Advisory Board, define the following with respect to operation of the HIE Network:

a. Business policy.

b. Protocols for data integrity, data sharing, data security, HIPAA compliance, and business intelligence as defined in G.S. 143B-426.38A. To the extent permitted by HIPAA, protocols for data sharing shall allow for the disclosure of data for academic research.

c. Qualitative and quantitative performance measures.

d. An operational budget and assumptions.

(16) Annually report to the Joint Legislative Oversight Committees on the Health Benefits Authority and Information Technology on the following:

a. The operation of the HIE Network.

b. Any efforts or progress in expanding participation in the HIE Network.

c. Health care trends based on information disclosed through the HIE Network.

"**§ 90-414.6. North Carolina Health Information Exchange Advisory Board.**

(a) Creation and Membership. – There is hereby established the North Carolina Health Information Exchange Advisory Board within the Office of Information Technology Services. The Advisory Board shall consist of the following nine members:

(1) The following three members appointed by the President Pro Tempore of the Senate:
a. A licensed physician in good standing and actively practicing in this State.
b. A patient representative.
c. An individual with technical expertise in health data analytics.
(2) The following three members appointed by the Speaker of the House of Representatives:
a. A representative of a critical access hospital.
b. A representative of a federally qualified health center.
c. An individual with technical expertise in health information technology.
(3) The following three ex officio, nonvoting members:
a. The State Chief Information Officer or a designee.
b. The Program Manager of GDAC or a designee.
c. The Chief Executive Officer of the Health Benefits Authority or a designee.

(b) Chairperson. – A chairperson shall be elected from among the members. The chairperson shall organize and direct the work of the Advisory Board.

(c) Administrative Support. – The Office of Information Technology Services shall provide necessary clerical and administrative support to the Advisory Board.

(d) Meetings. – The Advisory Board shall meet at least quarterly and at the call of the chairperson. A majority of the Advisory Board constitutes a quorum for the transaction of business.

(e) Terms. – In order to stagger terms, in making initial appointments, the President Pro Tempore of the Senate shall designate two of the members appointed under subdivision (1) of subsection (a) of this section to serve for a one-year period from the date of appointment and, the Speaker of the House of Representatives shall designate two members appointed under subdivision (2) of subsection (a) of this section to serve for a one-year period from the date of appointment. The remaining voting members shall serve two-year periods. Future appointees who are voting members shall serve terms of two years, with staggered terms based on this subsection. Voting 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. Ex officio, nonvoting members are not subject to these term limits. A vacancy other than by expiration of a term shall be filled by the appointing authority.

(f) Expenses. – Members of the Advisory Board who are State officers or employees shall receive no compensation for serving on the Advisory Board but may be reimbursed for their expenses in accordance with G.S. 138-6. Members of the Advisory Board who are full-time salaried public officers or employees other than State officers or employees shall receive no compensation for serving on the Advisory Board but may be reimbursed for their expenses in accordance with G.S. 138-5(b). All other members of the Advisory Board may receive compensation and reimbursement for expenses in accordance with G.S. 138-5.

(g) Duties. – The Advisory Board shall provide consultation to the Authority with respect to the advancement, administration, and operation of the HIE Network and on matters pertaining to health information exchange, generally. In carrying out its responsibilities, the Advisory Board may form committees of the Advisory Board to examine particular issues related to the advancement, administration, or operation of the HIE Network.

"**§ 90-414.7. Participation by covered entities.**

(a) Each covered entity that elects to participate in the HIE Network shall enter into a business associate contract and a written participation agreement with the Authority or

qualified organization prior to disclosing or accessing any protected health information through the HIE Network.

(b) Each covered entity that elects to participate in the HIE Network may authorize its business associates to disclose or access protected health information on behalf of the covered entity through the HIE Network in accordance with this Article and at the discretion of the Authority, as provided in G.S. 90-414.5(b)(8).

(c) Notwithstanding any State law or regulation to the contrary, each covered entity that elects to participate in the HIE Network may disclose an individual's protected health information through the HIE Network (i) to other covered entities for any purpose permitted by HIPAA, unless the individual has exercised the right to opt out, and (ii) in order to facilitate the provision of emergency medical treatment to the individual, subject to the requirements set forth in G.S. 90-414.8(e).

(d) Any health care provider who relies in good faith upon any information provided through the Authority or through a qualified organization in the health care provider's treatment of a patient shall not incur criminal or civil liability for damages caused by the inaccurate or incomplete nature of this information.

"**§ 90-414.8. Continuing right to opt out; effect of opt out; exception for emergency medical treatment.**

(a) Each individual has the right on a continuing basis to opt out or rescind a decision to opt out.

(b) The Authority or its designee shall enforce an individual's decision to opt out or rescind an opt out prospectively from the date the Authority or its designee receives notice of the individual's decision to opt out or rescind an opt out in the manner prescribed by the Authority. An individual's decision to opt out or rescind an opt out does not affect any disclosures made by the Authority or covered entities through the HIE Network prior to receipt by the Authority or its designee of the individual's notice to opt out or rescind an opt out.

(c) A covered entity may not deny treatment or benefits to an individual because of the individual's decision to opt out. However, nothing in this Article is intended to restrict a treating physician from otherwise appropriately terminating a relationship with a patient in accordance with applicable law and professional ethical standards.

(d) Except as otherwise permitted in subsection (e) of this section and G.S. 90-414.9(a)(3), the protected health information of an individual who has exercised the right to opt out may not be disclosed to covered entities through the HIE Network for any purpose.

(e) The protected health information of an individual who has exercised the right to opt out may be disclosed through the HIE Network in order to facilitate the provision of emergency medical treatment to the individual if all of the following criteria are met:

(1) The reasonably apparent circumstances indicate to the treating health care provider that (i) the individual has an emergency medical condition, (ii) a meaningful discussion with the individual about whether to rescind a previous decision to opt out is impractical due to the nature of the individual's emergency medical condition, and (iii) information available through the HIE Network could assist in the diagnosis or treatment of the individual's emergency medical condition.

(2) The disclosure through the HIE Network is limited to the covered entities providing diagnosis and treatment of the individual's emergency medical condition.

(3) The circumstances and extent of the disclosure through the HIE Network is recorded electronically in a manner that permits the Authority or its designee to periodically audit compliance with this subsection.

"**§ 90-414.9. Construction and applicability.**

(a) Nothing in this Article shall be construed to do any of the following:
(1) Impair any rights conferred upon an individual under HIPAA, including all of the following rights related to an individual's protected health information:
a. The right to receive a notice of privacy practices.
b. The right to request restriction of use and disclosure.
c. The right of access to inspect and obtain copies.
d. The right to request amendment.
e. The right to request confidential forms of communication.
f. The right to receive an accounting of disclosures.
(2) Authorize the disclosure of protected health information through the HIE Network to the extent that the disclosure is restricted by federal laws or regulations, including the federal drug and alcohol confidentiality regulations set forth in 42 C.F.R. Part 2.
(3) Restrict the disclosure of protected health information through the HIE Network for public health purposes or research purposes, so long as disclosure is permitted by both HIPAA and State law.
(4) Prohibit the Authority or any covered entity participating in the HIE Network from maintaining in the Authority's or qualified organization's computer system a copy of the protected health information of an individual who has exercised the right to opt out, as long as the Authority or the qualified organization does not access, use, or disclose the individual's protected health information for any purpose other than for necessary system maintenance or as required by federal or State law.

(b) This Article applies only to disclosures of protected health information made through the HIE Network, including disclosures made within qualified organizations. It does not apply to the use or disclosure of protected health information in any context outside of the HIE Network, including the redisclosure of protected health information obtained through the HIE Network.

"**§ 90-414.10. Penalties and remedies.**

A covered entity that discloses protected health information in violation of this Article is subject to the following:
(1) Any civil penalty or criminal penalty, or both, that may be imposed on the covered entity pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act, P.L. 111-5, Div. A, Title XIII, section 13001, as amended, and any regulations adopted under the HITECH Act.
(2) Any civil remedy under the HITECH Act or any regulations adopted under the HITECH Act that is available to the Attorney General or to an individual who has been harmed by a violation of this Article, including damages, penalties, attorneys' fees, and costs.
(3) Disciplinary action by the respective licensing board or regulatory agency with jurisdiction over the covered entity.
(4) Any penalty authorized under Article 2A of Chapter 75 of the General Statutes if the violation of this Article is also a violation of Article 2A of Chapter 75 of the General Statutes.
(5) Any other civil or administrative remedy available to a plaintiff by State or federal law or equity."

SECTION 2.(e) G.S. 126-5(c1) is amended by adding a new subdivision 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:

…

(32) Employees of the North Carolina Health Information Exchange Authority."

SECTION 2.(f) Article 29A of Chapter 90 of the General Statutes is repealed.

SECTION 2.(g) Subsections (d) and (e) of this section become effective October 1, 2015. Subsection (f) of this section becomes effective on the date the State Chief Information Officer notifies the Revisor of Statutes that all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE, as defined in G.S. 90-413.3, and (ii) between the NC HIE and any third parties have been terminated or assigned to the North Carolina Health Information Exchange Authority established under Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section. The remainder of this section becomes effective July 1, 2015.

INCREASE RATES TO PRIMARY CARE PHYSICIANS AND DISCONTINUE PRIMARY CARE CASE MANAGEMENT

SECTION 3.(a) Effective May 1, 2016, the current Medicaid and Health Choice primary care case management (PCCM) program is discontinued. The Department of Health and Human Services shall not renew or extend the contract for PCCM services with North Carolina Community Care Networks, Inc. (NCCCN), beyond April 30, 2016.

SECTION 3.(b) The Department of Health and Human Services shall take all actions necessary to discontinue the current Medicaid and Health Choice PCCM program as implemented by NCCCN. As soon as reasonably possible, but no later than February 1, 2016, the Department shall submit to the Centers for Medicare and Medicaid Services (CMS) a Medicaid State plan amendment eliminating the PCCM program. If CMS has not approved the State plan amendment by May 1, 2016, the Department of Health and Human Services nevertheless shall discontinue all payments related to the PCCM program beginning May 1, 2016, unless and until CMS denies the State plan amendment.

SECTION 3.(c) This section shall not be construed to prohibit the Department of Health and Human Services from developing or utilizing contracts for managed care other than PCCM after May 1, 2016.

SECTION 3.(d) Effective May 1, 2016, G.S. 108A-70.21(b) reads as rewritten:

"(b) Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

…

No benefits are to be provided for services and materials under this subsection that do not meet the standards accepted by the American Dental Association.

~~The Department shall provide services to children enrolled in the NC Health Choice Program through Community Care of North Carolina (CCNC) and shall pay Community Care of North Carolina providers the per member, per month fees as allowed under Medicaid.~~"

SECTION 3.(e) Effective May 1, 2016, the rates paid to primary care physicians shall be one hundred percent (100%) of Medicare rates. For purposes of this section, the term primary care physicians refers to those physicians for whom the Affordable Care Act required payment at one hundred percent (100%) of the Medicare rate until January 1, 2015, and all OB/GYN physicians.

SECTION 3.(f) The General Assembly finds that the discontinuation of the PCCM program and the NCCCN contract as required by this section will save a recurring sum of ten million eight hundred twenty-five thousand dollars ($10,825,000) in fiscal year 2015-2016 and

sixty-four million nine hundred fifty thousand dollars ($64,950,000) in fiscal year 2016-2017. As a result of these savings, appropriations are made as follows: the recurring sum of eight million four hundred thirty-four thousand three hundred thirteen dollars ($8,434,313) in fiscal year 2015-2016 and fifty million six hundred five thousand eight hundred eighty dollars ($50,605,880) in fiscal year 2016-2017 is appropriated to the Department of Health and Human Services, Division of Medical Assistance, to pay for the increased Medicaid rates required by subsection (e) of this section, and the recurring sum of two million one hundred fifty-eight thousand three hundred thirty-three dollars ($2,158,333) in fiscal year 2015-2016 and twelve million nine hundred fifty thousand dollars ($12,950,000) in fiscal year 2016-2017 is appropriated to the Department of Health and Human Services, Division of Medical Assistance, to directly fund local health departments' continued services related to the Care Coordination for Children (CC4C) program, which was previously funded through the contract with NCCCN.

SECTION 3.(g) This section is effective when this act becomes law.

SECTION 4. Except as otherwise provided, this act is effective when it becomes law.