GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

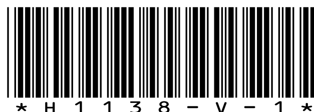
H **1**

HOUSE BILL 1138

Short Title:	Aging With Dignity Act.	(Public)
Sponsors:	Representatives Ball, G. Pierce, G. Brown, and Pittman (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Appropriations, if favorable, Rules, Calendar, and Operations of the House	

May 4, 2026

1 A BILL TO BE ENTITLED
2 AN ACT PROMOTING AGING WITH DIGNITY BY STRENGTHENING HOME- AND
3 COMMUNITY-BASED CARE; IMPROVING LONG-TERM CARE OVERSIGHT;
4 SUPPORTING FAMILY CAREGIVERS AND THE GERIATRIC WORKFORCE;
5 APPROPRIATING FUNDS FOR STRATEGIC STATE INVESTMENTS TO MEET THE
6 NEEDS OF NORTH CAROLINA'S GROWING SENIOR POPULATION; AND
7 REESTABLISHING A STUDY COMMISSION ON AGING.
8 The General Assembly of North Carolina enacts:
9
10 **PART I. LEGISLATIVE FINDINGS**
11 **SECTION 1.1.** The General Assembly finds all of the following:
12 (1) North Carolina's population aged 65 and older is growing rapidly and is
13 projected to exceed 2.4 million residents by 2030, significantly increasing
14 demand for long-term services and supports.
15 (2) Older adults overwhelmingly prefer to remain in their homes and communities
16 when appropriate, yet access to home- and community-based services is
17 limited by workforce shortages, long waitlists, geographic disparities, and
18 administrative barriers.
19 (3) Institutional long-term care is costly to individuals, families, and the State,
20 while preventable hospitalizations, falls, medication-related injuries, and
21 delayed discharges contribute to unnecessary Medicaid expenditures and
22 strain the health care system.
23 (4) North Carolina relies on a direct care workforce that experiences low wages,
24 high turnover, limited career advancement opportunities, and growing
25 shortages that threaten access to safe and timely care for older adults.
26 (5) Family caregivers provide substantial unpaid care that reduces reliance on
27 institutional care and public expenditures, yet frequently lack adequate
28 financial support, respite services, and care coordination resources.
29 (6) The State has a responsibility to ensure that long-term care facilities operate
30 with transparency, accountability, and a focus on resident dignity, safety, and
31 quality of life and that regulatory and advocacy programs are adequately
32 staffed and empowered to protect residents.
33 (7) Demographic trends, workforce constraints, and rising costs make
34 continuation of current long-term care policies unsustainable without targeted
35 reforms and strategic investments.



(8) A coordinated policy framework that prioritizes aging in place when appropriate, strengthens oversight of long-term care settings, supports caregivers and the geriatric workforce, and invests in high-value, person-centered care is necessary to protect older North Carolinians and ensure responsible stewardship of public resources.

PART II. IMPROVEMENT OF LONG-TERM SERVICES & SUPPORTS FOR MEDICAID BENEFICIARIES

HOME- AND COMMUNITY-BASED SERVICES PRESUMPTION FOR MEDICAID BENEFICIARIES

SECTION 2.1. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.5A. Presumption in favor of home- and community-based services for long-term services and supports.**

(a) Policy of the State. – It is the policy of the State that individuals aged 55 or older who require long-term services and supports funded in whole or in part by the medical assistance program should receive those services in the most integrated setting appropriate to their needs, consistent with federal law.

(b) Presumption Established. – Except as provided in subsection (e) of this section, for purposes of Medicaid-funded long-term services and supports, home- and community-based services shall be presumed to be the preferred setting of care unless institutional placement is determined to be medically necessary.

(c) Medical Necessity Determination. – An individual aged 55 or older may be placed in, or remain in, an institutional long-term care setting, including a nursing facility or a Medicaid-funded adult care home, only upon a documented determination that home- and community-based services are insufficient to meet the individual's assessed clinical, functional, or safety needs.

(d) Assessment and Documentation. – The determination required under subsection (c) of this section shall include all of the following:

(1) A standardized assessment approved by the Department.

(2) Written clinical justification supporting the need for institutional placement.

(3) A periodic reassessment at intervals established by the Department.

(e) Individual Choice. – Nothing in this section shall be construed to limit an individual's right to choose an institutional setting when otherwise eligible, provided the individual has been informed of available home- and community-based service options.

(f) Department Authority. – The Department shall implement this section and may adopt rules and policies necessary to carry out its provisions, including establishing clinical criteria, defining exceptions, and seeking any necessary federal approvals, waivers, or amendments to the Medicaid State Plan."

POLYPHARMACY REVIEW FOR MEDICAID BENEFICIARIES RECEIVING LONG-TERM SERVICES AND SUPPORTS

SECTION 2.2. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.5B. Medication review for individuals receiving long-term services and supports.**

(a) Findings and Purpose. – The General Assembly finds that the use of multiple concurrent medications is associated with increased risk of falls, cognitive impairment, hospitalization, and diminished quality of life among older adults. The purpose of this section is

to reduce preventable harm and unnecessary health care expenditures by ensuring regular, comprehensive medication review for individuals receiving long-term services and supports.

(b) Medication Review Required. – The Department shall ensure that individuals aged 55 or older receiving Medicaid-funded long-term services and supports are provided periodic medication reviews to identify potentially inappropriate medications, duplicative therapies, adverse drug interactions, and opportunities for medication optimization.

(c) Scope of Review. – Medication reviews under this section shall include all of the following:

(1) A review of all prescription medications and, to the extent feasible, over-the-counter medications and supplements known to be used by the individual.

(2) A consideration of the cumulative medication burden, drug-drug interactions, and drug-condition interactions.

(3) An evaluation of medications associated with increased risk of falls, sedation, confusion, or functional decline.

(4) Documentation in the individual's care record.

(d) Qualified Reviewers. – Medication reviews shall be conducted by a licensed pharmacist, physician, or other qualified health care professional authorized by the Department and acting within the scope of licensure.

(e) Deprescribing Authority. – The Department may adopt rules to allow for deprescribing or medication modification when clinically appropriate, including processes for communication and coordination among prescribers, pharmacists, care managers, and the individual or the individual's representative.

(f) Integration with Care Planning. – Medication review findings under this section shall be incorporated into the individual's care plan and used to inform service authorization, care coordination, and reassessment decisions.

(g) Implementation Flexibility. – The Department may implement this section through managed care contracts, clinical policy, or other administrative mechanisms and may prioritize implementation for individuals at highest risk of medication-related harm."

INTEGRATION OF BEHAVIORAL HEALTH AND GERIATRIC CARE FOR MEDICAID BENEFICIARIES

SECTION 2.3. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.5C. Integration of behavioral health services for older adults receiving long-term services and supports.**

(a) Purpose. – The purpose of this section is to ensure that older adults receiving Medicaid-funded long-term services and supports have access to age-appropriate, dementia-capable behavioral health services in order to improve quality of life, reduce preventable hospitalizations, and decrease reliance on inappropriate sedation or chemical restraint.

(b) Integration Requirement. – The Department shall ensure that behavioral health assessment, treatment, and care coordination are integrated into the delivery of Medicaid-funded long-term services and supports for adults aged 55 or older, including individuals with dementia or cognitive impairment.

(c) Scope of Services. – Behavioral health integration under this section shall include all of the following:

(1) Screening and assessment for depression, anxiety, dementia-related behavioral symptoms, and other geriatric behavioral health needs.

(2) Access to mental health and substance use disorder services delivered by clinicians with training or experience in geriatric care.

(3) Dementia-capable behavioral health interventions designed to address behavioral symptoms without unnecessary reliance on pharmacological treatment.

(4) Care coordination among primary care providers, behavioral health providers, pharmacists, and long-term services and supports providers.

(5) Crisis intervention strategies that reduce avoidable emergency department visits and hospitalizations.

(d) Medication Practices. – The Department shall promote care models and clinical practices that prioritize nonpharmacological and person-centered interventions for behavioral symptoms in adults aged 55 or older and shall discourage the use of antipsychotics, sedatives, or other medications when not clinically indicated.

(e) Implementation. – The Department may adopt rules to implement this section through clinical policy, managed care contracts, provider standards, care management requirements, or other administrative mechanisms and may prioritize implementation for individuals at highest risk of behavioral health-related hospitalization or institutional placement.

(f) Training and Workforce Support. – The Department may support training and technical assistance for providers and care managers to build geriatric behavioral health and dementia-capable care expertise."

RECOGNITION OF SOCIAL ISOLATION AND LONELINESS IN CARE PLANNING FOR OLDER ADULT MEDICAID BENEFICIARIES

SECTION 2.4. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.5D. Screening for social isolation and loneliness; care coordination and referral.**

(a) Purpose. – The purpose of this section is to improve early identification and intervention for social isolation and loneliness among older adults receiving Medicaid-funded long-term services and supports in order to prevent avoidable health decline, functional impairment, and progression to more serious mental health conditions.

(b) Screening Authorized. – The Department shall authorize and promote screening for social isolation and loneliness among adults aged 55 or older receiving Medicaid-funded long-term services and supports, using evidence-based screening tools approved by the Department.

(c) Care Coordination and Referral. – When screening indicates significant social isolation or loneliness, the Department shall ensure that those findings may be used to do any of the following:

(1) Trigger care coordination activities.

(2) Prompt referral for further clinical evaluation, including behavioral health assessment when appropriate.

(3) Inform individualized care planning and service authorization decisions.

(d) Covered Services. – Social isolation and loneliness, when identified through authorized screening, shall be recognized as valid factors for purposes of Medicaid-funded care coordination, assessment, and referral services. Nothing in this section shall be construed to require coverage of room and board or nonmedical housing costs.

(e) Clinical Evaluation Not Precluded. – A finding of social isolation or loneliness shall not be used as a substitute for clinical evaluation. The Department shall ensure that symptoms associated with loneliness are appropriately addressed and, when indicated, evaluated for depression, anxiety, cognitive impairment, or other diagnosable conditions.

(f) Implementation. – The Department may adopt rules to implement this section through clinical policy, care management requirements, managed care contracts, or other administrative

mechanisms and may prioritize implementation for individuals at higher risk of hospitalization, functional decline, or institutional placement."

PART III. APPROPRIATIONS FOR STRATEGIC STATE INVESTMENTS TO MEET THE NEEDS OF NORTH CAROLINA'S GROWING SENIOR POPULATION

INTEGRATED SENIOR HOUSING AND CARE PILOT PROGRAM

SECTION 3.1.(a) The Department of Health and Human Services shall establish and conduct an integrated senior housing and care pilot program (pilot program). The purpose of the pilot program is to initiate a public-private partnership to plan, design, construct, and launch a housing-first residential facility that integrates on-site medical, behavioral health, pharmacy, rehabilitative, and supportive services for older adults who rely heavily on Medicare and Medicaid services.

SECTION 3.1.(b) In designing, constructing, and launching the housing-first residential facility for use in the pilot program, the Department of Health and Human Services and any entity selected to partner with the Department of Health and Human Services shall adhere to all of the following requirements:

(1) The facility shall consist of not more than 300 residential units located at a single site.
(2) The facility shall be operated as housing-first, with residents retaining tenancy rights and receiving health and supportive services through integrated on-site or affiliated providers.
(3) The facility shall be designed to serve individuals who are dually eligible for Medicare and Medicaid, and participation in Medicaid-funded services is a condition of all pilot program participants, including facility residents and entities that partner with the Department of Health and Human Services to operate the facility.
(4) The facility shall be designed to reduce care fragmentation and unnecessary transitions by providing coordinated, interdisciplinary services on-site or through formal partnerships.

SECTION 3.1.(c) The Department of Health and Human Services is authorized to do all of the following to establish and conduct the pilot program:

(1) Implement a selection process for contracting with one or more nonprofit organizations, local governments, or private entities to design, construct, launch, and operate the facility.
(2) Structure the pilot program as a public-private partnership by leveraging both public and private sector expertise and a mixture of funding sources, including public sector grants, loans provided by public or private institutions or both, and other financing mechanisms.
(3) Coordinate with other State agencies and seek federal approvals, waivers, or financing mechanisms to support the pilot program.
(4) Adopt rules as necessary to carry out the pilot program.

SECTION 3.1.(d) There is appropriated from the General Fund to the Department of Health and Human Services the sum of one hundred twenty million dollars ($120,000,000) in nonrecurring funds for the 2026-2027 fiscal year to establish and conduct the integrated senior housing and care pilot program authorized by this section. Funds appropriated by this subsection shall not be used for any purposes other than the following:

(1) Site acquisition, planning, and design costs.
(2) Predevelopment and construction costs.
(3) Capital costs necessary to integrate on-site clinical and supportive service capacity.

(4) Start-up and initial operating costs, including those associated with staffing, care coordination infrastructure, and program launch expenses, as determined necessary by the Department of Health and Human Services.

Notwithstanding G.S. 143C-1-2(b) or any other provision of law to the contrary, funds appropriated by this subsection shall not revert at the end of the 2026-2027 fiscal year but shall remain available for the purposes authorized by this subsection until expended.

SECTION 3.1.(e) Beginning May 1, 2028, and annually thereafter for as long as funds appropriated by this section remain available for expenditure, the Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the implementation status and operation of the integrated senior housing and care pilot program authorized by this section. Beginning one year after initial occupancy of the housing-first residential facility funded by subsection (d) of this section, the report required by this section shall include at least all of the following information regarding the occupants of that residential facility:

(1) The number of residents and their demographic data, including, at a minimum, their age and sex.
(2) Medicaid and Medicare utilization trends.
(3) Rates of hospitalization, institutional placement, and transitions of care.
(4) Quality-of-life and resident satisfaction measures.
(5) Lessons learned and recommendations regarding scalability or replication of this pilot program.

SECTION 3.1.(f) The pilot program authorized by this section terminates at the end of the fiscal year in which the funds appropriated pursuant to subsection (d) of this section are expended.

STRENGTHENING THE LONG-TERM CARE OMBUDSMAN PROGRAM

SECTION 3.2.(a) The Department of Health and Human Services, Division of Aging, Office of the State Long-Term Care Ombudsman, shall work toward strengthening the State Long-Term Care Ombudsman Program (Ombudsman Program) by improving access to Ombudsman Program services; reducing the backlog of complaints received by the Ombudsman Program; improving response times in high-priority cases involving immediate threats to the health, safety, or rights of residents in long-term care facilities; and enhancing coordination with other entities responsible for protecting the rights of residents in long-term care facilities, regulating long-term care facilities, or a combination of those.

SECTION 3.2.(b) No later than January 1, 2027, the Department of Health and Human Services, Division of Aging, Office of the State Long-Term Care Ombudsman, shall develop and begin implementing a staffing and regional coverage plan for the Ombudsman Program that accomplishes all of the following:

(1) Identifies staffing vacancies, workload pressures, and regional service gaps.
(2) Establishes priorities for hiring additional State and regional ombudsman personnel.
(3) Improves timely on-site response capacity in high-priority cases.
(4) Supports complaint intake, complaint investigation, complaint resolution, and follow-up.
(5) Provides for training, travel, case management, and administrative support for State and regional ombudsman personnel as necessary to fulfill the objectives of the Ombudsman Program.

SECTION 3.2.(c) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging, Office of the State Long-Term Care Ombudsman, the sum of three million five hundred thousand dollars ($3,500,000) in recurring funds beginning in the 2026-2027 fiscal year to improve the Ombudsman Program as specified

in subsection (a) of this section and to implement the staffing and regional coverage plan described in subsection (b) of this section. Funds appropriated by this subsection shall not be used for any purposes other than the following:

(1) Hiring additional State and regional ombudsman personnel.
(2) Expanding access to the Ombudsman Program, complaint intake, investigation, resolution, and follow-up capacity.
(3) Supporting travel, training, case management systems, and administrative functions for State and regional ombudsman personnel.
(4) Strengthening coordination with the Division of Health Service Regulation; county departments of social services; Adult Protective Services; legal services providers; and other entities responsible for the protection of residents in long-term care facilities, the regulation of long-term care facilities, or a combination of those.
(5) Reducing complaint backlogs and improving response times in high-priority cases.
(6) Supporting data collection, reporting, and program administration necessary to carry out this section.

SECTION 3.2.(d) No later than December 1, 2027, and annually thereafter, the Department of Health and Human Services, Division of Aging, Office of the State Long-Term Care Ombudsman, shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the implementation status of this section. The report shall include at least all of the following information regarding the activities of the Ombudsman Program:

(1) The number and type of complaints received.
(2) Average response times and average resolution times.
(3) Complaint backlogs, staffing vacancies, and regional coverage gaps.
(4) Referrals made to regulatory, protective, or law enforcement agencies.
(5) The use of funds appropriated by subsection (c) of this section.
(6) Any recommendations for administrative or legislative action.

GERIATRIC WORKFORCE PIPELINE AND DIRECT CARE CAREER ADVANCEMENT PROGRAM

SECTION 3.3.(a) Article 3 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-181.27. Geriatric workforce pipeline and direct care career advancement program.**

(a) The Department of Health and Human Services (DHHS), in consultation with the North Carolina Community Colleges System Office, The University of North Carolina System Office, the North Carolina Independent Colleges and Universities, the Department of Commerce, and relevant licensing boards, shall establish a geriatric workforce pipeline and direct care career advancement program (the program). The purpose of the program is to increase the supply, geographic distribution, retention, and advancement of workers prepared to serve older adults in a diversity of settings, including home- and community-based settings, nursing facilities, adult care homes, and hospitals.

(b) The program shall be designed to achieve all of the following goals:

(1) Establish geriatric care training pathways for nurses, physicians, social workers, pharmacists, behavioral health professionals, direct care workers, and other relevant personnel.
(2) Establish partnerships with community colleges and employers to create stackable, portable credentials for direct care workers and other frontline personnel serving older adults.

(3) Establish career ladder models that support advancement from entry-level direct care roles into more specialized or higher-paid roles.

(4) Implement recruitment initiatives targeted to rural counties, underserved communities, and areas experiencing workforce shortages in geriatric and long-term care settings.

(5) Establish clinical training, apprenticeships, preceptorships, internships, or other work-based learning opportunities in geriatric and long-term care settings.

(6) Improve retention supports for the geriatric workforce, including mentoring, supervision, and continuing education.

(7) Elicit recommendations for the modernization of scope-of-practice laws, rules, or supervision requirements, where appropriate, to improve access to safe and timely geriatric care while maintaining patient protections.

(c) Subject to available appropriations, the program may fund loan forgiveness, forgivable loans, tuition assistance, or similar incentives for eligible individuals who commit to practicing in geriatric, long-term care, or direct care service settings in this State for a minimum period of time established by the DHHS.

(d) In administering the program, the DHHS shall prioritize workforce investments that expand service capacity for Medicaid beneficiaries, individuals with dementia, family caregiver support programs, and older adults residing in rural or high-need areas.

(e) Credentials developed under this program shall, to the extent practicable, be recognized across participating employers and training institutions in order to facilitate worker mobility, advancement, and retention.

(f) No later than October 1 of each year, the DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Education Oversight Committee, and the Fiscal Research Division on the implementation status and operation of the program. The report shall include, at a minimum, the following information:

(1) Enrollment data for all training and education pathways developed under the program.

(2) A description of any stackable, portable credentials developed under the program for direct care workers and other frontline personnel serving older adults and the number of individuals who obtained these credentials.

(3) The number of vacancies filled as a result of the program.

(4) An evaluation of the retention rates of direct care workers and other frontline personnel as a result of the program.

(5) Any recommended legislative changes to improve program administration or to increase the supply, geographic distribution, retention, and advancement of workers prepared to serve older adults in a diversity of settings.

(g) Rules. – The DHHS may adopt rules to implement the program."

SECTION 3.3.(b) There is appropriated from the General Fund to the Department of Health and Human Services the sum of ten million dollars ($10,000,000) in recurring funds beginning in the 2026-2027 fiscal year to implement the geriatric workforce pipeline and direct care career advancement program authorized by G.S. 143B-181.27, as enacted by subsection (a) of this section.

FAMILY CAREGIVER SUPPORT STIPEND PILOT PROGRAM

SECTION 3.4.(a) The purpose of the proposed family caregiver support stipend pilot program (the pilot program) is to reduce caregiver burnout, delay or prevent avoidable institutionalization, and support older adults who choose to remain in their homes and communities by authorizing a targeted Medicaid-funded family caregiver support stipend, subject to federal approval and available appropriations.

SECTION 3.4.(b) The Department of Health and Human Services, Division of Health Benefits (DHB), is directed to take all actions necessary to support implementation of the pilot program for eligible family caregivers of Medicaid beneficiaries receiving long-term services and supports that meets the requirements of this section, including, as applicable, submitting any necessary documentation to the Centers for Medicare and Medicaid Services (CMS), including State Plan Amendments and waiver amendments.

SECTION 3.4.(c) DHB shall only implement the pilot program described in this section if any necessary submissions to CMS under subsection (b) of this section are approved.

SECTION 3.4.(d) The monthly stipend provided under the pilot program shall be a maximum of four hundred dollars ($400.00) to each eligible family caregiver per eligible care recipient.

SECTION 3.4.(e) DHB shall adopt rules or clinical coverage policies, as appropriate, establishing eligibility criteria for care recipients and family caregivers for the pilot program, that shall include at least all of the following:

(1) The care recipient is an older adult or other individual receiving Medicaid-funded long-term services and supports who would, in the absence of caregiver support, be at increased risk of hospitalization, institutional placement, or other higher-cost care.

(2) The care recipient is living in a home- or community-based setting.

(3) The family caregiver provides substantial assistance with activities of daily living, instrumental activities of daily living, supervision, or other support identified by DHB.

(4) The family caregiver satisfies any training, documentation, and program integrity requirements established by DHB.

SECTION 3.4.(f) DHB shall adopt rules or clinical coverage policies, as appropriate, establishing guardrails for the pilot program, which may include any of the following:

(1) Limits on duplication of payment where the family caregiver is otherwise compensated through another Medicaid service category for the same service.

(2) Documentation requirements of caregiving activities.

(3) Family caregiver training requirements.

(4) Care assessments and periodic reassessments.

(5) Fraud prevention and recovery procedures.

(6) Safeguards to protect beneficiary choice, health, safety, and quality of care.

SECTION 3.4.(g) No later than six months after receiving any federal approval on any submissions under subsection (b) of this section, and annually thereafter for any year in which the pilot program is implemented under this section, DHB shall report to the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division. This report shall include all of the following, as applicable:

(1) An overview of implementation activities.

(2) The number of family caregivers and care recipients participating in the pilot program.

(3) An overview of total expenditures on the pilot program.

(4) An evaluation of the pilot program outcomes with respect to all of the following:

a. Caregiver burden.

b. Beneficiary satisfaction.

c. Avoidable hospitalizations.

d. Nursing facility admissions.

e. Medicaid cost avoidance.

f. Other measures as DHB deems appropriate.

(5) Any recommended legislative changes.

SECTION 3.4.(h) Nothing in this section shall be construed to create an entitlement to a stipend absent federal approval and an appropriation enacted by the General Assembly.

SECTION 3.4.(i) There is appropriated from the General Fund to DHB the sum of thirteen million five hundred thousand dollars ($13,500,000) in recurring funds beginning in the 2026-2027 fiscal year and the sum of seven hundred fifty thousand dollars ($750,000) in nonrecurring funds for the 2026-2027 fiscal year to be used to implement this section. The funds appropriated under this subsection shall not be used for any other purpose and shall revert at the end of the fiscal year in which they are appropriated if not expended.

SECTION 3.4.(j) This section shall expire two years after it becomes law.

PART IV. REESTABLISHMENT OF STUDY COMMISSION ON AGING

SECTION 4.1.(a) Commission Created; Purpose. – There is created the Aging Study Commission (Commission) for the purpose of studying and recommending legislative and policy changes necessary for North Carolina to respond to the needs of its aging population, particularly as the first wave of the baby boom generation reaches advanced age beginning in 2026.

SECTION 4.1.(b) Duties. – In studying and recommending legislative policy changes necessary for North Carolina to respond to the needs of its aging population, the Commission shall examine at least all of the following issues related to aging:

(1) Long-term services and supports, including home- and community-based services and institutional care.
(2) Workforce capacity and training for geriatric and direct care professions.
(3) Support for family caregivers.
(4) Housing, transportation, and community infrastructure necessary to support aging in place.
(5) Accessibility and quality of health care for older adults, including integrated behavioral health and dementia-capable services.
(6) Financing and sustainability of services for older adults, including through Medicaid and other programs of public assistance.
(7) Oversight, quality, and accountability in long-term care settings.
(8) Legislative proposals to implement the findings of the Governor's Advisory Council on Aging.

SECTION 4.1.(c) Membership. – The Commission shall consist of the following 15 voting members and five ex officio, nonvoting members:

(1) Six members appointed by the President Pro Tempore of the Senate; the persons appointed may be members of the Senate or public members.
(2) Six members appointed by the Speaker of the House of Representatives; the persons appointed may be members of the House of Representatives or public members.
(3) Three public members appointed by the Governor.
(4) The following ex officio, nonvoting members or their designees:
    a. The Secretary of the Department of Health and Human Services.
    b. The Director of the Division of Aging.
    c. The Director of the Division of Health Benefits.
    d. The Secretary of Commerce.
    e. A representative of the Governor's Council on Aging.

Appointing authorities may consider geographic diversity and subject-matter expertise when making their appointments. Any vacancies on the Commission shall be filled by the original appointing authorities.

SECTION 4.1.(d) Meetings. – The Commission shall meet at the call of the cochairs. The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate one cochair from among the legislative members.

1 **SECTION 4.1.(e)** Staffing and Assistance. – The Legislative Services Office shall
2 provide staff support to the Commission. The Commission may request assistance from State
3 agencies, academic institutions, and subject-matter experts as necessary to carry out its duties.
4 **SECTION 4.1.(f)** Report. – The Commission shall submit a report of its findings
5 and recommendations, including any recommended legislation, to the General Assembly no later
6 than December 31, 2027.
7 **SECTION 4.1.(g)** Sunset. – The Commission shall terminate upon the submission
8 of its report to the General Assembly, unless extended by an act of the General Assembly.
9
10 **PART V. EFFECTIVE DATE**
11 **SECTION 5.1.** Except as otherwise provided, this act is effective July 1, 2026.