GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

HOUSE BILL 696
RATIFIED BILL

AN ACT MAKING VARIOUS CHANGES TO THE MEDICAID PROGRAM AND OTHER CHANGES RELATED TO HEALTH AND HUMAN SERVICES, IMPLEMENTING VARIOUS BUDGETARY ADJUSTMENTS, AND MAKING OTHER CHANGES IN THE BUDGET OPERATIONS OF THE STATE.

The General Assembly of North Carolina enacts:

PART I. GENERAL PROVISIONS

EXTENSION OF CERTAIN DIRECTED GRANT REVERSIONS

SECTION 1.1.(a) Section 5.3 of S.L. 2023-134, as amended by Section 1.3(a) of S.L. 2024-1, reads as rewritten:

"…

"**SECTION 5.3.(b)** Requirements. – Nonrecurring funds appropriated in this act as directed grants are subject to all of the following requirements:

…

(4) Notwithstanding any provision of G.S. 143C-1-2(b) to the contrary, nonrecurring funds appropriated in this act for the 2023-2024 fiscal year and the 2024-2025 fiscal year as directed grants shall not revert until June 30, ~~2026.~~2027.

(5) Directed grants to nonprofit organizations are for nonsectarian, nonreligious purposes only.

"**SECTION 5.3.(c)** This section expires on June 30, ~~2026.~~2027."

SECTION 1.1.(b) Section 1.1(b) of S.L. 2025-4 reads as rewritten:

"**SECTION 1.1.(b)** Any funds described in subsection (a) of this section that remain unexpended as of December 31, 2024, shall revert to the appropriate fund at the end of the ~~2025-2026~~ 2026-2027 fiscal year."

SECTION 1.1.(c) This section is effective June 30, 2026.

PART II. EDUCATION

NORTH CAROLINA BLUE RIBBON COMMISSION ON PUBLIC EDUCATION

SECTION 2.1.(a) There is established the North Carolina Blue Ribbon Commission on Public Education (Commission).

SECTION 2.1.(b) Membership. – The Commission consists of the following 29 members:

(1) Nineteen voting members appointed jointly by the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Governor.

(2) Five nonvoting members of the Senate appointed jointly by the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Governor.

(3) Five nonvoting members of the House of Representatives jointly appointed by the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Governor.

SECTION 2.1.(c) Terms; Chairs; Vacancies; Quorum. – Members serve at the pleasure of the appointing officers. The President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Governor shall jointly designate cochairs. The Commission shall meet upon the call of the cochairs at any date prior to the Commission's termination. The appointing authorities shall fill any vacancy on the Commission. A quorum for action by the Commission is a majority of its voting members.

SECTION 2.1.(d) Duties. – The Commission shall study the structure and implementation of public education in the State. The Commission may examine any of the following:

(1) Teacher training and student advancement.
(2) Administrative operations.
(3) Educational leadership in the State.
(4) Accountability.

SECTION 2.1.(e) Administration. – The Friday Institute for Educational Innovation at North Carolina State University (Friday Institute) shall provide professional, clerical, and consultant services to the Commission. The Legislative Services Officer shall assign professional and clerical staff to provide technical assistance to the Commission and the Friday Institute upon request of the President Pro Tempore of the Senate and the Speaker of the House of Representatives.

SECTION 2.1.(f) Compensation. – Members of the Commission shall receive per diem, subsistence, and travel allowance as provided in G.S. 120-3.1, 138-5, and 138-6, as appropriate.

SECTION 2.1.(g) Report; Termination. – The Commission may submit interim reports and a final report on the results of its work, including any proposed recommendations, to the General Assembly and the Governor. The Commission shall submit reports to the General Assembly in accordance with G.S. 120-29.5. The Commission terminates March 1, 2027.

SECTION 2.1.(h) There is appropriated from the General Fund to the Board of Governors of The University of North Carolina the sum of three hundred thousand dollars ($300,000) in nonrecurring funds for the 2025-2026 fiscal year to be allocated to the Friday Institute for the administration of the Commission in accordance with this section. Funds appropriated pursuant to this section shall not revert at the end of the 2025-2026 fiscal year but shall remain available until June 30, 2027.

CONFORM ELIGIBLE EXPENSES FOR NORTH CAROLINA 529 PLANS TO FEDERAL LAW

SECTION 2.2. G.S. 116-209.25(b) reads as rewritten:

"(b) Parental Savings Trust Fund. – There is established a parental savings trust fund to be administered by the State Education Assistance Authority to enable qualified parents and other interested parties to save funds to meet the costs of education expenses of eligible students in accordance with section 529 of the ~~Code. For purposes of this section, the term "Code" has the same meaning as defined in G.S. 105-228.90.~~Internal Revenue Code as enacted as of July 4, 2025, including any provisions enacted as of that date that become effective either before or after that date."

FUNDS FOR RECIPIENTS OF THE CHILDREN OF WARTIME VETERANS SCHOLARSHIP IN THE 2025-2026 ACADEMIC YEAR

SECTION 2.3. There is appropriated from the General Fund to the Board of Governors of The University of North Carolina for the 2025-2026 fiscal year the sum of one

million dollars ($1,000,000) in nonrecurring funds to be allocated to the State Education Assistance Authority (Authority) to increase award amounts for recipients of scholarships for the children of wartime veterans for the 2025-2026 academic year up to the full amounts permitted under Part 2 of Article 14 of Chapter 143B of the General Statutes to the extent those award amounts were reduced by the Secretary of the Department of Military and Veterans Affairs pursuant to the award flexibility provided in Part VI of S.L. 2025-72. If any of these funds remain after increasing award amounts for scholarship recipients in accordance with this section, the Authority may use the remaining funds to award additional scholarships for qualifying children of wartime veterans under Part 2 of Article 14 of Chapter 143B of the General Statutes, beginning in the 2026-2027 academic year.

FUNDS FOR ADDITIONAL AWARDS FOR THE CHILDREN OF WARTIME VETERANS SCHOLARSHIP IN THE 2026-2027 ACADEMIC YEAR

SECTION 2.4.(a) Notwithstanding G.S. 143B-1226, for new applications for scholarships for children of wartime veterans under Part 2 of Article 14 of Chapter 143B of the General Statutes, the Secretary of the Department of Military and Veterans Affairs may increase the number of Class II and Class III scholarships awarded in the 2026-2027 academic year from 100 to 200 children in each class.

SECTION 2.4.(b) There is appropriated from the Escheat Fund to the Board of Governors of The University of North Carolina the sum of ten million dollars ($10,000,000) in recurring funds beginning in the 2026-2027 fiscal year to be allocated to the State Education Assistance Authority to support additional scholarships for qualifying children of wartime veterans under Part 2 of Article 14 of Chapter 143B of the General Statutes in accordance with subsection (a) of this section.

SECTION 2.4.(c) This section becomes effective July 1, 2026.

EXPAND EXISTING FLEXIBILITY FOR THE CHILDREN OF WARTIME VETERANS SCHOLARSHIP FUNDS PROGRAM TO INCLUDE THE 2026-2027 ACADEMIC YEAR

SECTION 2.5. Section 6 of S.L. 2025-72 reads as rewritten:

"**SECTION 6.(a)** For purposes of subsection (b) of this section, the following definitions shall apply:

(1) Authority. – The State Education Assistance Authority.
(2) Commission. – The Veterans' Affairs Commission of the Department.
(3) Department. – The Department of Military and Veterans Affairs.
(4) Program. – The program administered by the Department to award scholarship funds that is referred to as Scholarships for Children of Wartime Veterans.
(5) Scholarship funds. – Scholarship funds awarded to the child of a North Carolina veteran under Part 2 of Article 14 of Chapter 143B of the General Statutes.
(6) Secretary. – The Secretary of the Department of Military and Veterans Affairs.

"**SECTION 6.(b)** Notwithstanding Part 2 of Article 14 of Chapter 143B of the General Statutes and any rules adopted or determinations made by the Veterans Affairs Commission, for the ~~2024-2025 academic year and the 2025-2026 academic year,~~ 2024-2025, 2025-2026, and 2026-2027 academic years, the following shall apply relating to the administration of scholarship funds under the Program:

(1) Within funds available for the Program, the following shall be determined:
    a. Due to the sacrifice of veterans for the State of North Carolina and the unique needs and challenges of the children of wartime veterans to ensure they have the greatest opportunities to reach their higher education attainment goals, if there are additional eligible recipients,

other than those identified by the Department under this Program, who are attending public colleges and universities of the State who may qualify to have their scholarships funded with monies from the Escheat Fund, the Authority, after consultation with the Secretary, may fund those scholarships with monies from the Escheat Fund.

b. For the 2025-2026 and 2026-2027 academic years, the following shall occur:

1. After consultation with the Authority, the Secretary shall determine whether to prioritize the award of new applicants ~~for the 2025-2026 academic year in~~ as follows:

I. In Class I-A, I-B, and IV scholarships, prior to awarding Class II and III scholarships. Class II and Class III awards may be determined following awards for Class I-A, I-B, and IV depending on the availability of funds for the Program.

II. For the 2026-2027 academic year only, in scholarships for new applicants who meet the following requirements:

A. Apply to receive scholarships as undergraduate students.

B. Qualify as residents for tuition purposes under the criteria set forth in G.S. 116-143.1 and in accordance with the coordinated and centralized residency determination process administered by the Authority.

C. Are otherwise eligible to receive scholarships in accordance with the Program requirements.

~~c.~~2. The Secretary, after consulting with the Authority, may determine the following based on the number of eligible students, including new and renewal ~~students, that have applied for the 2025-2026 academic year,~~ students:

I. For the 2025-2026 academic year, whether to reduce the room and board allowance award for students attending a public institution and the maximum allowance award for students attending private institutions, prior to August 15, 2025.

II. For the 2026-2027 academic year, whether to establish a standardized payment schedule or formula within available funds for the academic year to ensure the efficient and effective administration of the scholarships.

~~d.~~3. ~~After the actions set forth in sub-subdivisions a., b., and c. of this subdivision have been taken, for awards for the 2025-2026 academic year,~~ After the preceding actions have been taken, if funds available for the Program are still insufficient to provide scholarships to all eligible students, the Authority may adjust and standardize award amounts as necessary, including establishing a lottery and providing pro rata scholarship awards for room and board, or both, for the applicable academic year, to ensure the efficient administration of the scholarship funds.

(2) All scholarship notifications shall include language that the award of the scholarship is contingent upon the availability of funds.

(3) The Authority shall disburse scholarship funds in accordance with G.S. 116-204(11a).

(4) From the total amount of funding appropriated to the Board of Governors of The University of North Carolina and allocated to the Authority in a fiscal year to support the award of scholarship funds under the Program, the Authority may use an amount of up to two and one-half percent (2.5%) for administration costs related to the Program from the allocation from the General Fund. The Authority shall place any unexpended and unencumbered appropriated funds remaining at the end of the ~~2024-2025 and 2025-2026 fiscal years~~ 2024-2025, 2025-2026, and 2026-2027 fiscal years into an institutional trust fund established in accordance with the provisions of G.S. 116-36.1. Those funds may be used for the purpose of awarding scholarships under the Program and for administration costs of the Authority related to the Program.

"**SECTION 6.(c)** This section becomes effective June 30, 2025, and applies to awards granted for the ~~2024-2025 and 2025-2026 academic years.~~2024-2025, 2025-2026, and 2026-2027 academic years."

PART III. HEALTH AND HUMAN SERVICES

PART III-A. DEFINITIONS

SECTION 3A.1. The following definitions apply in this Part:

(1) CMS. – The federal Centers for Medicare and Medicaid Services.

(2) NC RHTP. – The North Carolina Rural Health Transformation Plan approved and funded by CMS as part of the Rural Health Transformation Program.

(3) Public Law 119-21. – The Reconciliation Act of 2025, Public Law 119-21, 139 Stat. 72 (2025), also known as the "One Big Beautiful Bill Act."

(4) RHTP or Rural Health Transformation Program. – The Rural Health Transformation Program authorized by section 71401 of Public Law 119-21 and administered by CMS.

(5) SNAP. – The federal Supplemental Nutrition Assistance Program, also known as the State Food and Nutrition Services (FNS) program.

(6) Subrecipient. – A nonfederal entity that receives a subaward from the North Carolina Department of Health and Human Services to carry out activities related to the NC Rural Health Transformation Plan.

PART III-B. DIVISION OF CENTRAL MANAGEMENT AND SUPPORT

PERIODIC REPORTING ON THE NORTH CAROLINA RURAL HEALTH TRANSFORMATION PLAN

SECTION 3B.1.(a) The Department of Health and Human Services (DHHS) shall submit periodic progress reports to the Joint Legislative Commission on Governmental Operations on the implementation status of the NC RHTP according to the following schedule:

Reporting Period	Due Date
August 1, 2026-October 30, 2026	November 29, 2026
October 31, 2026-January 30, 2027	March 1, 2027
January 31, 2027-April 30, 2027	May 30, 2027
May 1, 2027-July 31, 2027	August 30, 2027

August 1, 2027-October 30, 2027	November 29, 2027
October 31, 2027-January 30, 2028	February 28, 2028
January 31, 2028-April 30, 2028	May 30, 2028
May 1, 2028-July 31, 2028	August 30, 2028
August 1, 2028-October 30, 2028	November 29, 2028
October 31, 2028-January 30, 2029	March 1, 2029
January 31, 2029-April 30, 2029	May 30, 2029
May 1, 2029-July 31, 2029	August 30, 2029
August 1, 2029-October 30, 2029	November 29, 2029
October 31, 2029-January 30, 2030	February 28, 2030
January 31, 2030-April 30, 2030	May 30, 2030
May 1, 2030-July 31, 2030	August 30, 2030
August 1, 2030-October 30, 2030	November 29, 2030

SECTION 3B.1.(b) Each report submitted to the Commission pursuant to subsection (a) of this section shall include at least all of the following information for the relevant reporting period:

(1) A copy of the quarterly or annual report submitted by the DHHS to CMS, as required by the RHTP Cooperative Agreement in effect between the DHHS and CMS.

(2) A summary or copies of all verbal and written updates provided by the DHHS to the CMS Rural Health Transformation Program Official.

(3) The total amount of funds allocated to each initiative identified in the NC RHTP.

(4) The total amount of funds awarded to subrecipients in each county, broken down as follows:

a. A list identifying each subrecipient.

b. For each subrecipient, all of the following information:

1. The total amount of funds awarded to the subrecipient.

2. A brief description of the subrecipient's funded activities.

3. A list of counties where the subrecipient is located.

4. A list of counties served by the subrecipient's funded activities.

PART III-C. DIVISION OF HEALTH BENEFITS

DURATION OF MEDICAID PROGRAM MODIFICATIONS

SECTION 3C.1. Except for statutory changes or where otherwise specified, the Department of Health and Human Services shall not be required to maintain, after June 30, 2027, any modifications to the Medicaid program required by this Part.

MEDICAID REBASE FUNDING

SECTION 3C.2.(a) Notwithstanding the limitations under G.S. 143C-4-11 on the use, allocation, and expenditure of funds reserved in the Medicaid Contingency Reserve, there is appropriated from the Medicaid Contingency Reserve to the Department of Health and Human Services, Division of Health Benefits, the sum of three hundred nineteen million dollars ($319,000,000) in nonrecurring funds and associated receipts for the 2025-2026 fiscal year to be used to adjust Medicaid funding to account for projected changes in enrollment, enrollment mix, service and capitation costs, and federal match rates, as well as the implementation of the Children and Families Specialty Plan in December 2025.

SECTION 3C.2.(b) This section is retroactively effective July 1, 2025.

LME/MCO INTERGOVERNMENTAL TRANSFERS

SECTION 3C.3.(a) The local management entities/managed care organizations (LME/MCOs) shall make intergovernmental transfers to the Department of Health and Human Services, Division of Health Benefits (DHB), in an aggregate amount of eighteen million twenty-eight thousand two hundred seventeen dollars ($18,028,217) in the 2025-2026 fiscal year and in an aggregate amount of eighteen million twenty-eight thousand two hundred seventeen dollars ($18,028,217) for the 2026-2027 fiscal year. The due date and frequency of the intergovernmental transfer required by this section shall be determined by DHB. The amount of the intergovernmental transfer that each individual LME/MCO is required to make in each fiscal year shall be as follows:

	2025-2026	**2026-2027**
Alliance Behavioral Healthcare	$4,508,857	$4,508,857
Partners Health Management	$3,544,348	$3,544,348
Trillium Health Resources	$6,448,693	$6,448,693
Vaya Health	$3,526,319	$3,526,319

SECTION 3C.3.(b) In the event that a county disengages from an LME/MCO and realigns with another LME/MCO during the 2025-2027 fiscal biennium, DHB shall have the authority to reallocate the amount of the intergovernmental transfer that each affected LME/MCO is required to make under subsection (a) of this section, taking into consideration the change in catchment area and covered population, provided that the aggregate amount of the transfers received from all LME/MCOs in each year of the fiscal biennium is achieved.

SECTION 3C.3.(c) This section is retroactively effective July 1, 2025.

TECHNICAL UPDATES TO COMPLY WITH H.R.1

SECTION 3C.4.(a) G.S. 108A-54.3A(a)(24) reads as rewritten:

"(24) Individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act who are in compliance ~~with~~ with, or are exempt from, any ~~federally approved work requirements established in the State Plan and in rule.~~ applicable community engagement requirements. Coverage for individuals under this subdivision is available through an Alternative Benefit Plan that is established by the Department consistent with federal requirements, unless that individual is exempt from mandatory enrollment in an Alternative Benefit Plan under 42 C.F.R. § 440.315."

SECTION 3C.4.(b) G.S. 108A-54.3A, as amended by subsection (a) of this section, reads as rewritten:

"**§ 108A-54.3A. Eligibility categories and income thresholds.**

(a) The Department shall provide Medicaid coverage for individuals in accordance with federal statutes and regulations and specifically shall provide ~~coverage~~ coverage, subject to the limitation in subsection (c) of this section, for the following populations:

…

~~(22) Refugees, in accordance with 8 U.S.C. § 1522.~~

~~(23) Qualified aliens subject to the five-year bar for means tested public assistance under 8 U.S.C. § 1613 and undocumented aliens, only for emergency services under 8 U.S.C. § 1611.~~

…

(c) Medicaid coverage for individuals who are not citizens of the United States shall be limited to coverage that is federally required for the State's participation in the Medicaid program."

SECTION 3C.4.(c) G.S. 108D-40 reads as rewritten:

"**§ 108D-40. Populations covered by PHPs.**

(a) Capitated PHP contracts shall cover all Medicaid program aid categories except for the following categories:

…

~~(2) Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611.~~

(3) ~~Undocumented aliens who qualify for~~ Aliens whose Medicaid coverage is limited to emergency services under 8 U.S.C. § 1611.

…."

SECTION 3C.4.(d) Subsections (b) and (c) of this section are effective October 1, 2026. The remainder of this section is effective when it becomes law.

COMMUNITY ENGAGEMENT REQUIREMENTS

SECTION 3C.5.(a) Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-55.7. Community engagement requirements.**

(a) As long as work requirements as a condition of participation in the Medicaid program may be authorized by the Centers for Medicare and Medicaid Services, the Department shall take all actions necessary to implement and maintain implementation of those work requirements to the fullest extent allowable.

(b) At the time of initial application for medical assistance benefits, the applicant shall provide satisfactory proof that the applicant has complied with any applicable community engagement requirements for the three consecutive months immediately preceding the month the applicant submits the application for medical assistance benefits.

(c) At the time of redetermination of eligibility for medical assistance benefits, the applicant shall provide satisfactory proof that the applicant has complied with any applicable community engagement requirements for at least three of the last six months immediately preceding the month of the redetermination."

SECTION 3C.5.(b) This section is effective January 1, 2027.

MONTHLY DATA CHECKS

SECTION 3C.6.(a) G.S. 108A-55.5 reads as rewritten:

"**§ 108A-55.5. Eligibility monitoring for medical assistance.**

(a) On at least a ~~quarterly~~ monthly basis, the Department shall review information concerning changes in circumstances that may affect medical assistance beneficiaries' eligibility to receive medical assistance benefits. The Department shall share the information directly with, or make the information available to, the county department of social services that determined the beneficiary's eligibility.

(b) The information reviewed by the Department shall include all of the following:

(1) Earned and unearned income.
(2) Employment status and changes in employment.
(3) Residency status.
(4) Enrollment status in other State-administered public assistance programs.
(5) Financial resources.
(6) Incarceration status.
(7) Death records.
(8) Lottery and gambling winnings.
(9) Enrollment status in public assistance programs outside of this State.

…."

SECTION 3C.6.(b) This section is effective October 1, 2026.

LIMIT USE OF SELF-ATTESTATION IN VERIFYING MEDICAID ELIGIBILITY

SECTION 3C.7.(a) Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-55.6. Verification of Medicaid eligibility; limitations.**

Except as required by federal law or regulation, or pursuant to a court order, the Department or a county department of social services shall not accept self-attestation as the only evidence in verification of eligibility requirements for the North Carolina Medicaid program."

SECTION 3C.7.(b) This section is effective October 1, 2026.

HOUSEHOLD MEMBER INCOME INFORMATION

SECTION 3C.8.(a) Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-55.8. Household members.**

Except as otherwise provided by federal law or regulation, the income of a household member who is ineligible for medical assistance benefits due to the household member's immigration status shall be counted when calculating and determining an individual's financial eligibility for medical assistance benefits."

SECTION 3C.8.(b) This section is effective October 1, 2026.

CONFIDENTIALITY OF RECORDS EXCEPTION

SECTION 3C.9.(a) G.S. 108A-80 reads as rewritten:

"**§ 108A-80. Confidentiality of records.**

(a) Except as provided in subsections ~~(b) and (b1)~~ (b), (b1), and (b2) of this section, it shall be unlawful for any person to obtain, ~~disclose~~ disclose, or use, or to authorize, permit, or acquiesce in the use ~~of~~ of, any list of names or other information concerning persons applying for or receiving public assistance or social services that may be directly or indirectly derived from the records, ~~files~~ files, or communications of the Department or the county boards of social services, or county departments of social services or acquired in the course of performing official duties except for the purposes directly connected with the administration of the programs of public assistance and social services in accordance with federal law, ~~rules~~ rules, and regulations, and the rules of the Social Services Commission or the Department.

…

(b2) The Department shall promptly refer any applicant or recipient for which citizenship or satisfactory immigration status could not be verified to the United States Department of Homeland Security or any other appropriate federal authority for investigation and enforcement. This referral shall be made if either of the following occurs:

(1) After a reasonable opportunity period to verify citizenship or satisfactory immigration status, the status could not be verified.

(2) Upon receipt of verification, the verification indicates that the applicant or recipient (i) is not a United States citizen or lacks satisfactory immigration status and (ii) has entered the United States without inspection or admission, or has remained beyond the expiration of an authorized period of stay.

…."

SECTION 3C.9.(b) This section is effective October 1, 2026.

MEDICAID PROGRAM AND NCWORKS CAREER CENTERS AUDIT

SECTION 3C.10.(a) The Office of the State Auditor shall conduct a performance audit of the administration of the North Carolina Medicaid program and the NCWorks Career Centers. The audit shall consider any information deemed necessary by the State Auditor to evaluate the administration of these programs.

SECTION 3C.10.(b) Effective July 1, 2026, there is appropriated from the General Fund to the Office of the State Auditor the sum of five hundred thousand dollars ($500,000) in

nonrecurring funds for the 2026-2027 fiscal year to be used to conduct the performance audit required by subsection (a) of this section.

ANNUAL FRAUD, WASTE, AND ABUSE REPORTING

SECTION 3C.11. Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-64.2. Annual fraud, waste, and abuse reporting.**

No later than October 1 of each year, the Department shall submit a report to the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division. The report shall contain all of the following for the most recently concluded State fiscal year:

(1) An accounting of all improper Medicaid payments and expenditures, including the individual claim dollar amounts and total dollar amounts that were determined to be fraudulent, waste, or abuse.

(2) The total amount of federal and State recovered funds, including the dollar amount per claim and the total dollar amount concerning Medicaid fraud, waste, and abuse.

(3) Aggregate data concerning improper payments and ineligible Medicaid recipients who received Medicaid services as a percentage of those investigated or reviewed."

PREPAID HEALTH PLAN PROVIDER NETWORKS

SECTION 3C.12.(a) G.S. 108D-22 reads as rewritten:

"**§ 108D-22. PHP provider networks.**

(a) Provider Networks. – Except as provided in ~~G.S. 108D-23 and G.S. 108D-24,~~ G.S. 108D-23(c) and G.S. 108D-24(b), each PHP shall develop and maintain ~~a provider~~ an open network of providers that meets access to care requirements for its enrollees. ~~A PHP may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, a PHP must include all providers in its geographical coverage area that are designated essential providers by the Department in accordance with subdivision (b) of this section, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.~~

(b) Essential Providers. – A PHP must include all providers in its geographical coverage area that are designated essential providers by the Department, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers. The Department shall designate Medicaid providers as essential providers if, within a region defined by a reasonable access standard, the provider either (i) offers services that are not available from any other provider in the region or (ii) provides a substantial share of the total units of a particular service utilized by Medicaid beneficiaries within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid enrollees. The Department shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

(1) Federally qualified health centers.

(2) Rural health centers.

(3) Free clinics.

(4) Local health departments.

(5) State Veterans Homes.

(c) Exceptions for Individual Providers. – Individual providers, except for designated essential providers, may be excluded from the PHP open network for any of the following reasons:

(1) A provider fails to meet objective quality standards.

(2) A provider refuses to accept the network rates.

(3) In accordance with G.S. 108C-7(e3).

(d) Closed Networks for Designated Service Categories. – If an open network for a designated service category would jeopardize quality of care, program integrity, or cost-effective use of Medicaid funds, then, notwithstanding subsection (a) of this section, a PHP may develop a closed network for that designated service category and exclude providers that are not designated essential providers from that closed network. Prior to creating a closed network for a designated service category, the PHP must receive approval from the Department of the PHP's written request to close its provider network for that service category. This written request must include a demonstration of ongoing network adequacy. If the Department does not respond to a written request from a PHP for approval to close its provider network for a designated service category within 180 days after the request was submitted, the request is deemed approved."

SECTION 3C.12.(b) G.S. 108D-23 reads as rewritten:

"**§ 108D-23. BH IDD tailored plan provider networks.**

(a) Each LME/MCO shall operate provider networks with respect to its BH IDD tailored plan contract in accordance with this ~~section.~~section and G.S. 108D-22.

~~(b) With regard to services and supports that are covered benefits under both standard benefit plans and BH IDD tailored plans, each LME/MCO shall be subject to the same provider network requirements applicable to PHPs under G.S. 108D-22.~~

(c) With regard to services and supports that are excluded from PHP coverage except under BH IDD tailored plans, each LME/MCO shall ~~operate~~ develop a closed ~~network, which is the network of providers that have contracted with the LME/MCO to provide those services to enrollees,~~ network and may exclude providers from that closed network in accordance with all of the following:

(1) A closed network must include all essential providers designated in accordance with G.S. 108D-22(b) that (i) are located or provide services within the region for which the LME/MCO holds a BH IDD tailored plan contract and (ii) provide any covered behavioral health, intellectual and developmental disability, or traumatic brain injury service in that region.

(2) With regard to services identified by the Department as necessary to improve access for behavioral health, intellectual and developmental disability, and traumatic brain injury services, an LME/MCO shall accept all providers of those services that (i) meet objective quality standards and (ii) accept network rates, notwithstanding the requirement to operate a closed ~~network.~~network, except that a provider may be excluded in accordance with G.S. 108C-7(e3)."

SECTION 3C.12.(c) G.S. 108D-24 reads as rewritten:

"**§ 108D-24. Children and families specialty plan networks.**

(a) The entity operating the children and families specialty plan shall ~~develop and maintain a closed network of providers only as provided in this section.~~operate provider networks in accordance with this section and G.S. 108D-22.

(b) ~~The requirement to operate a closed network is applicable only to~~ The entity operating the children and families specialty plan shall develop a closed network, and may exclude providers from that closed network, for the provision of the following services:

(1) Intensive in-home services.

(2) Multisystemic therapy.

(3) Residential treatment services.

(4) Services provided in psychiatric residential treatment facilities.

~~(c) A closed network is the network of providers that have contracted with the entity operating the CAF specialty plan to provide to enrollees the services described in subsection (b) of this section.~~

(d) ~~The~~ In addition to the requirement to cover essential providers under G.S. 108D-22, the entity operating the CAF specialty plan shall not exclude federally recognized tribal providers or Indian Health Service providers from ~~its closed~~ any provider network."

PREPAYMENT CLAIMS REVIEW

SECTION 3C.13.(a) G.S. 108C-2 is amended by adding a new subdivision to read:

"(9a) Prepaid health plan or PHP. – As defined in G.S. 108D-1."

SECTION 3C.13.(b) G.S. 108C-7 reads as rewritten:

"**§ 108C-7. Prepayment claims review.**

(a) In order to ensure that claims presented by a provider for payment by the Department meet the requirements of federal and State laws and regulations and medical necessity criteria, a provider may be required to undergo prepayment claims review by the Department. Grounds for being placed on prepayment claims review shall include, but shall not be limited to, receipt by the Department of credible allegations of fraud, identification of aberrant billing practices as a result of investigations, data analysis performed by the Department, the failure of the provider to timely respond to a request for documentation made by the Department or one of its authorized representatives, or other grounds as defined by the Department in rule.

(b) Providers shall not be entitled to payment prior to claims review by the Department. The Department shall notify the provider in writing of the decision and the process for submitting claims for prepayment claims review. The written notice shall be deposited, first-class postage prepaid, in the United States mail and addressed to the most recent address given by the provider to the Department. The prepayment claims review shall not be instituted ~~no less than 20 calendar days from~~ prior to the date of the mailing of written notification. The notice shall contain all of the following:

…

(e) The provider shall remain subject to the prepayment claims review process until the provider achieves three consecutive months with a minimum ~~seventy~~ eighty percent ~~(70%)~~ (80%) clean claims rate, provided that the number of claims submitted per month is no less than fifty percent (50%) of the provider's average monthly submission of Medicaid claims for the three-month period prior to the provider's placement on prepayment review. If a provider does not submit any claims following placement on prepayment review in any given month, then the claims accuracy rating shall be zero percent (0%) for each month in which no claims were submitted. If the provider does not meet the ~~seventy~~ eighty percent ~~(70%)~~ (80%) clean claims rate minimum requirement for three consecutive months within six months of being placed on prepayment claims review, the Department may implement sanctions, including termination of the applicable Medicaid Administrative Participation Agreement, or continuation of prepayment review. The Department shall give adequate advance notice of any modification, suspension, or termination of the Medicaid Administrative Participation Agreement.

~~Prepayment claims review shall not continue longer than 24 consecutive months unless the Department has initiated the termination or other sanction of the provider and the provider has appealed that termination or sanction. If the Department has initiated the termination or other sanction of the provider and the provider has appealed that termination or sanction, then the provider shall remain on prepayment review until the final disposition of the Department's termination or other sanction of the provider.~~

(e1) Failure of a provider to meet the ~~seventy~~ eighty percent ~~(70%)~~ (80%) clean claims rate minimum requirement may result in a termination action. A termination action taken shall reflect the failure of the provider to meet the ~~seventy~~ eighty percent ~~(70%)~~ (80%) clean claims rate minimum requirement and shall result in exclusion of the provider from future participation in the Medicaid program. If a provider fails to meet the ~~seventy~~ eighty percent ~~(70%)~~ (80%) clean claims rate minimum requirement and subsequently requests a voluntary termination, the

termination shall reflect the provider's failure to successfully complete prepayment claims review and shall result in exclusion of the provider from future participation in the Medicaid program.

(e2) A provider shall not withhold claims to avoid the claims review process. Any claims for services provided during the period of prepayment review may still be subject to review prior to payment regardless of the date the claims are submitted and regardless of whether the provider has been taken off of prepayment review for any reason, including attaining a minimum of ~~seventy~~ eighty percent ~~(70%)~~ (80%) clean claims rate for three consecutive ~~months, the expiration of the 24-month time limit,~~ months or the termination of the provider.

(e3) In any contract with a PHP in which the Department authorizes a PHP to carry out the Department's authority under this section to require a provider to undergo prepayment claims review, all of the following shall apply:

(1) The Department shall not require the PHP to obtain approval from the Department before the prepayment claims review is instituted for a particular provider, unless the approval is required by federal law or regulation.

(2) When providing the notice required under subsection (b) of this section, a PHP shall send a copy of the notice to the Department.

(3) A PHP may exclude a provider from the PHP's network of providers if (i) the provider does not meet the eighty percent (80%) clean claims rate minimum requirement for three consecutive months within six months of being placed on prepayment claims review described in subsection (e) of this section and (ii) the PHP has received approval from the Department of the PHP's written request to remove that provider from the PHP's network of providers. If the Department does not respond to a written request from a PHP for approval to remove a provider from the PHP's network of providers within 90 days after the request was submitted, the request is deemed approved.

…."

SECTION 3C.13.(c) This section is effective when this act becomes law. Subsection (b) of this section applies to (i) prepayment claims reviews instituted on or after the effective date of this section and (ii) contracts entered into or amended on or after the effective date of this section.

PLAN FOR PROGRAM INTEGRITY AND EFFICIENCY

SECTION 3C.14.(a) The Department of Health and Human Services, Division of Health Benefits (DHB), is directed to develop a plan for improved health outcomes, program integrity, cost-savings, and efficiency measures in the Medicaid program. In developing this plan, DHB shall consult with relevant stakeholders. The plan shall include at least all of the following:

(1) Reduction of DHB administrative expenses through streamlining or standardization of DHB functions.

(2) Increased flexibilities for prepaid health plans (PHPs), as defined in G.S. 108D-1, to manage service utilization and costs and align claims operations with national standards and best practices.

(3) Alignment of rate schedule for inpatient hospital and hospital laboratory services that can be provided in an outpatient setting where appropriate. Where DHB determines the inpatient rate is higher than the outpatient rate, the plan required under this subsection shall include adjustment of DHB's schedule to the lower rate.

(4) Flexibilities for PHPs to manage utilization of glucagon-like peptide-1 (GLP-1) medications for weight loss, including mandatory participation in nutrition, weight loss, and lifestyle management programs. The plan required under this subsection shall not include any changes to the coverage of GLP-1

medications for diabetes, heart disease, or any indications other than weight loss.

(5) Improved alignment of Advanced Medical Home (AMH) and PHP contract incentives with PHP cost containment efforts through risk-sharing, value-based arrangements, and creation and appropriate oversight of quality standards for delegated care management entities. The plan required under this subsection shall include the removal of any prohibitions on PHPs from entering contracts with AMHs in which AMH and care management fees are at risk in value-based arrangements.

(6) Improved reporting on AMH care management activities including staffing, populations receiving different levels of care management, any measurable outcomes at each level of care management, and recommended legislative changes.

(7) Improved network management provider credentialing and certification tools for nonclinical providers to ensure qualified providers are delivering services and to expedite removal of non-qualified providers.

(8) Implementation of the plan required under this subsection no earlier than July 1, 2027.

SECTION 3C.14.(b) No later than October 1, 2026, DHB shall submit a report on the plan as required in subsection (a) of this section to the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division.

ALLOW CERTAIN PREPAID HEALTH PLAN PRACTICES

SECTION 3C.15.(a) G.S. 108D-65 reads as rewritten:

"**§ 108D-65. Role of the Department.**

(a) The role and responsibility of the Department during Medicaid transformation shall include the following activities and functions:

…

(b) Except as required by federal law or regulation, the Department shall not prohibit PHPs from requiring itemized bills for inpatient hospital outlier claims that are greater than two hundred fifty thousand dollars ($250,000) or more than two standard deviations from the median claim amount of the applicable billing code."

SECTION 3C.15.(b) This section is effective when it becomes law and applies to contracts entered into or amended on or after that date.

COST-SHARING

SECTION 3C.16.(a) Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-58.3. Cost-sharing.**

The Department shall annually establish all Medicaid copayments at the maximum allowable under federal law."

SECTION 3C.16.(b) This section is effective July 1, 2027.

EXTEND DURABLE MEDICAL EQUIPMENT RATES IN MEDICAID MANAGED CARE

SECTION 3C.17.(a) Section 11 of S.L. 2020-88, as amended by Section 3.6 of S.L. 2021-62, reads as rewritten:

"**SECTION 11.** For the first ~~five years~~ seven years, ending June 30, 2027, of the ~~initial~~ standard benefit plan prepaid health plan capitated contracts required under Article 4 of Chapter 108D of the General Statutes, the reimbursement for durable medical equipment and supplies, orthotics, and prosthetics under managed care shall be set at one hundred percent (100%) of the

lesser of the supplier's usual and customary rate or the maximum allowable Medicaid fee-for-service rates for durable medical equipment and supplies, orthotics, and prosthetics."

SECTION 3C.17.(b) This section is retroactively effective July 1, 2025.

MEDICAID COVERAGE FOR ABA THERAPY

SECTION 3C.18.(a) The Department of Health and Human Services, Division of Health Benefits (DHB), is directed to (i) amend and, if necessary, seek approval from the Centers for Medicare and Medicaid Services (CMS) for the changes to the NC Medicaid Clinical Coverage Policy 8F, Research-Based Behavioral Health Treatment (RB-BHT) For Autism Spectrum Disorder (CCP-8F), and (ii) adopt or amend any relevant rules to incorporate all of the following:

(1) Services under CCP-8F that are provided by a paraprofessional may not be conducted via telehealth unless exceptions are developed in accordance with subsection (b) of this section.

(2) Patient assessments by Licensed Qualified Autism Service Providers (LQASPs) are required to be conducted in person. Patient assessments conducted via telehealth shall not be reimbursed, unless exceptions are developed in accordance with subsection (b) of this section.

(3) Services under CCP-8F that are provided by a LQASP and that involve that LQASP's observation and direction of a paraprofessional may be conducted via telehealth. These telehealth services may not comprise more than fifty percent (50%) of the services provided by the LQASP under CCP-8F for any individual Medicaid recipient, unless exceptions are developed in accordance with subsection (b) of this section.

(4) At least ten percent (10%) of all services under CCP-8F that are provided by a paraprofessional must involve the observation and direction of the paraprofessional by a LQASP.

(5) LQASPs are required to develop, and ensure beneficiary compliance with, an individualized service plan for each Medicaid beneficiary. All of the following apply to the individualized service plan:

a. The plan is required to include minimum requirements of parent, guardian, or caretaker involvement and training services provided by the LQASP, unless exceptions are developed in accordance with subsection (b) of this section.

b. For any plan involving more than 16 hours of services per week, the plan must be approved by a PHP or the Department. These plans shall be updated and reapproved monthly.

(6) Parent, guardian, and caregiver training services provided by LQASPs under CCP-8F may be provided via telehealth with no in-person requirement.

(7) Paraprofessionals, including Registered Behavior Technicians and non-registered Technicians, providing services under CCP-8F shall be exempt from Medicaid credentialing requirements.

(8) Paraprofessionals who provide services under CCP-8F and are outside the 120-day grace period must have obtained a Registered Behavior Technician certification from the Behavior Analyst Certification Board (BACB) or an Applied Behavior Analysis Technician (ABAT) certification from the Qualified Applied Behavior Analysis Credentialing Board (QABA) in order for services provided to Medicaid recipients to be reimbursed. The 120-day grace period applies to newly hired paraprofessionals who have not yet obtained the necessary certification and is subject to all of the following:

a. The employee's 120-day grace period begins on the date of hire as a paraprofessional with a provider of Medicaid RB-BHT services or the date on which the employing provider of RB-BHT services first enrolls as a Medicaid provider, whichever is later.

b. The paraprofessional may provide, and the employing provider may bill, and be reimbursed for services provided by the paraprofessional during the grace period so long as each service provided is supervised by a LQASP.

(9) A provider providing services under CCP-8F shall ensure the percentage of services provided by LQASPs to each individual Medicaid beneficiary compared to services provided by paraprofessionals to that same beneficiary is in compliance with the requirements of this subdivision. The requirements only apply with respect to beneficiaries who received more than 200 hours of RB-BHT services from paraprofessionals employed by the provider in a six-month period. The provider shall provide DHB with documentation of compliance with these requirements every six months, in a manner and format to be determined by DHB. Services provided by LQASPs to each individual beneficiary shall be at least ten percent (10%), but no more than twenty percent (20%), of all services provided by paraprofessionals to that beneficiary, except that services that exceed twenty percent (20%) may be reimbursed with documented medical necessity. In order to calculate the percentage of services provided by LQASPs to each Medicaid beneficiary under this subdivision, the following numbers shall be used:

a. The numerator is the number of hours billed by the provider for services provided by LQASPs for all service dates occurring in the applicable six-month period for the Medicaid beneficiary.

b. The denominator is the number of hours billed by the provider for services provided by paraprofessionals for all service dates occurring in the applicable six-month period for that same Medicaid beneficiary.

SECTION 3C.18.(b) DHB may develop exceptions to the limitations in subdivisions (1) through (3) of subsection (a) of this section based upon documented medical necessity or access to care requirements, including poor provider availability in rural and underserved areas. Any exception developed in accordance with this subdivision shall be adopted in CCP-8F or other medical coverage policy in compliance with the requirements of G.S. 108A-54.2. When the notice required under G.S. 108A-54.2(b)(2) is given, DHB shall also submit a report to the chairs of the House Committee on Health, the Senate Committee on Health, the chairs of the Joint Legislative Oversight Committee on Medicaid, and the Joint Legislative Commission on Governmental Operations identifying the proposed exception and providing details supporting the need for the exception.

SECTION 3C.18.(c) G.S. 108C-9 is amended by adding a new subsection to read:

"(e) Board Certified Behavior Analysts and Qualified Autism Services Practitioner Supervisors shall not be permitted to enroll in the North Carolina Medicaid program as out-of-state providers."

SECTION 3C.18.(d) For noncompliance with any of the requirements set forth in this section, or rule adopted by DHB under this section, DHB may adopt rules to take any of the following actions against a provider:

(1) For a first or second occurrence of noncompliance, recoup payments for all relevant noncompliant services.

(2) For a third occurrence of material and systematic noncompliance, suspend the provider's eligibility to bill for Medicaid services for a minimum of one year to a maximum of two years.

SECTION 3C.18.(e) Subsection (c) of this section is effective when it becomes law and applies to all applications for enrollment submitted on or after that date. The remainder of this section is effective when it becomes law.

PART III-D. HOSPITAL ASSESSMENT ADJUSTMENTS

LEGISLATIVE INTENT

SECTION 3D.1. It is the intent of the General Assembly to provide funding for the increased administrative costs of compliance with frequency of eligibility redeterminations requirements and community engagement requirements in the Medicaid program under sections 71107 and 71119 of Public Law 119-21 from a source that meets the limitations on funding sources in G.S. 108A-54.3B for NC Health Works.

SHIFT EXISTING PUBLIC HOSPITAL ASSESSMENTS TO INTERGOVERNMENTAL TRANSFERS

SECTION 3D.2.(a) G.S. 108A-146.1 reads as rewritten:

"**§ 108A-146.1. Public hospital modernized assessment.**

(a) The public hospital modernized assessment imposed under this Part shall apply to all public acute care hospitals.

(b) The public hospital modernized assessment shall be assessed as a percentage of each public acute care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department of Health and Human Services in accordance with this Part. ~~The~~

(c) Through June 30, 2026, the percentage for each quarter shall equal the aggregate acute care hospital modernized assessment collection amount under G.S. 108A-146.5 multiplied by the public hospital historical assessment share and divided by the total hospital costs for all public acute care hospitals holding a license on the first day of the assessment quarter.

(d) Beginning July 1, 2026, the public hospital modernized assessment quarterly percentage shall equal the modernized IGT actual receipts adjustment component under G.S. 108A-146.14 divided by the total hospital costs for all public acute care hospitals holding a license on the first day of the assessment quarter."

SECTION 3D.2.(b) Part 2 of Article 7B of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-146.1A. Public hospital modernized presumptive IGT offset amount.**

The public hospital modernized presumptive IGT offset amount is the aggregate acute care hospital modernized assessment collection amount under G.S. 108A-146.5 multiplied by the public hospital historical assessment share."

SECTION 3D.2.(c) G.S. 108A-146.5 reads as rewritten:

"**§ 108A-146.5. Aggregate acute care hospital modernized assessment collection amount.**

(a) The aggregate modernized assessment collection amount is an amount of money that is calculated by subtracting the modernized ~~intergovernmental transfer~~ presumptive IGT adjustment component under G.S. 108A-146.13 from the total modernized nonfederal receipts under subsection (b) of this ~~section and then adding the positive or negative amount of the modernized IGT actual receipts adjustment component under G.S. 108A-146.14.~~section.

…."

SECTION 3D.2.(d) G.S. 108A-146.14 reads as rewritten:

"**§ 108A-146.14. Modernized IGT actual receipts adjustment component.**

The modernized IGT actual receipts adjustment component is a ~~positive or negative~~ dollar amount equal to the amount of the modernized presumptive IGT adjustment component under ~~G.S. 108A-146.13~~ G.S. 108A-146.13(c) for the previous quarter minus the amount of money received during the previous quarter by the Department through intergovernmental transfer and designated in the Department's accounting system as a receipt related to the modernized

assessments. If this calculation results in a negative number, the modernized IGT actual receipts adjustment component is zero."

SECTION 3D.2.(e) G.S. 108A-146.14, as amended by subsection (d) of this section, reads as rewritten:

"**§ 108A-146.14. Modernized IGT actual receipts adjustment component.**

The modernized IGT actual receipts adjustment component is a dollar amount equal to the amount of the modernized presumptive IGT adjustment component under G.S. 108A-146.13(c) for the previous quarter plus the public hospital modernized presumptive IGT offset amount under G.S. 108A-146.1A for the previous quarter minus the amount of money received during the previous quarter by the Department through intergovernmental transfer and designated in the Department's accounting system as a receipt related to the modernized assessments. If this calculation results in a negative number, the modernized IGT actual receipts adjustment component is zero."

SECTION 3D.2.(f) Subsection (e) of this section is effective October 1, 2026, and applies to assessments imposed on or after that date.

SECTION 3D.2.(g) G.S. 108A-147.1 reads as rewritten:

"**§ 108A-147.1. Public hospital health advancement assessment.**

(a) The public hospital health advancement assessment imposed under this Part shall apply to all public acute care hospitals.

(b) The public hospital health advancement assessment shall be assessed as a percentage of each public acute care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department in accordance with this Part. ~~The~~

(c) Through June 30, 2026, the percentage for each quarter shall equal the aggregate acute care hospital health advancement assessment collection amount calculated under G.S. 108A-147.3 multiplied by the public hospital historical assessment share and divided by the total hospital costs for all public acute care hospitals holding a license on the first day of the assessment quarter.

(d) Beginning July 1, 2026, the public hospital health advancement assessment quarterly percentage shall equal the health advancement IGT actual receipts adjustment component under G.S. 108A-147.10 divided by the total hospital costs for all public acute care hospitals holding a license on the first day of the assessment quarter."

SECTION 3D.2.(h) Part 3 of Article 7B of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-147.1A. Public hospital health advancement presumptive IGT offset amount.**

The public hospital health advancement presumptive IGT offset amount is the aggregate acute care hospital health advancement assessment collection amount under G.S. 108A-147.3 multiplied by the public hospital historical assessment share."

SECTION 3D.2.(i) G.S. 108A-147.3(a) reads as rewritten:

"(a) The aggregate health advancement assessment collection amount is an amount of money that is calculated quarterly by adjusting the total nonfederal receipts for health advancement calculated under subsection (b) of this section by ~~(i)~~ subtracting the health advancement presumptive IGT adjustment component calculated under ~~G.S. 108A-147.9, (ii) adding the positive or negative health advancement IGT actual receipts adjustment component calculated under G.S. 108A-147.10,~~ G.S. 108A-147.9 and ~~(iii)~~ then subtracting the positive or negative total IGT share of the reconciliation adjustment component calculated under ~~G.S. 108A-147.11(b).~~G.S. 108A-147.11(e)."

SECTION 3D.2.(j) G.S. 108A-147.10 reads as rewritten:

"**§ 108A-147.10. Health advancement IGT actual receipts adjustment component.**

The health advancement IGT actual receipts adjustment component is a ~~positive or negative~~ dollar amount equal to the health advancement presumptive IGT adjustment component calculated under G.S. 108A-147.9 for the previous quarter, plus the positive or negative total IGT

share of the reconciliation adjustment component calculated under ~~G.S. 108A-147.11(b)~~ G.S. 108A-147.11(e) for the previous quarter, and minus the amount of money received during the previous quarter by the Department through intergovernmental transfer and designated in the Department's accounting system as a receipt for health advancement. If this calculation results in a negative number, the health advancement IGT actual receipts adjustment component is zero."

SECTION 3D.2.(k) G.S. 108A-147.10, as amended by subsection (j) of this section, reads as rewritten:

"**§ 108A-147.10. Health advancement IGT actual receipts adjustment component.**

The health advancement IGT actual receipts adjustment component is a dollar amount equal to the total of (i) the amount of the health advancement presumptive IGT adjustment component calculated under G.S. 108A-147.9 for the previous quarter, ~~plus~~ (ii) the positive or negative total IGT share of the reconciliation adjustment component calculated under G.S. 108A-147.11(e) for the previous quarter, ~~and~~ and (iii) the public hospital health advancement presumptive IGT offset amount for the previous quarter, minus the amount of money received during the previous quarter by the Department through intergovernmental transfer and designated in the Department's accounting system as a receipt for health advancement. If this calculation results in a negative number, the health advancement IGT actual receipts adjustment component is zero."

SECTION 3D.2.(*l*) G.S. 108A-147.11 reads as rewritten:

"**§ 108A-147.11. Health advancement reconciliation adjustment component.**

(a) The health advancement reconciliation adjustment component is a positive or negative dollar amount equal to the actual nonfederal expenditures for the quarter that is two quarters prior to the current quarter minus the sum of the following specified amounts:

(1) The presumptive service cost component calculated under G.S. 108A-147.5 for the quarter that is two quarters prior to the current quarter.

(2) The amount transferred during the current quarter by the Department of Revenue to the State Treasurer for the Health Advancement Receipts Special Fund under G.S. 105-228.5C.

(3) The health advancement acute care hospital HASP component calculated under G.S. 108A-147.6 for the quarter that is two quarters prior to the current quarter.

(4) The health advancement freestanding psychiatric hospital HASP component calculated under G.S. 108A-147.6A for the quarter that is two quarters prior to the current quarter.

(b) The base IGT share of the reconciliation adjustment component is a positive or negative dollar amount that is calculated by multiplying the health advancement reconciliation adjustment component calculated under subsection (a) of this section by the share of public hospital costs calculated under subsection (c) of this section.

(c) The share of public hospital costs is calculated by adding total hospital costs for the UNC Health Care System, total hospital costs for the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine, and sixty percent (60%) of the total hospital costs for all public acute care hospitals and dividing that sum by the total hospital costs for all acute care hospitals except for critical access hospitals and rural emergency hospitals.

(d) The supplemental IGT share of the reconciliation adjustment component is a positive or negative dollar amount that is calculated by subtracting the base IGT share of the reconciliation adjustment component calculated under subsection (b) of this section from the health advancement reconciliation component calculated under subsection (a) of this section and multiplying that difference by the public hospital historical assessment share.

(e) The total IGT share of the reconciliation adjustment component is a positive or negative dollar amount that is the sum of the base IGT share of the reconciliation adjustment component calculated under subsection (b) of this section and the supplemental IGT share of the reconciliation adjustment component calculated under subsection (d) of this section."

SECTION 3D.2.(m) Subsection (k) of this section is effective October 1, 2026, and applies to assessments imposed on or after that date.

SECTION 3D.2.(n) Except as otherwise provided, this section is effective July 1, 2026, and applies to assessments imposed on or after that date.

THE 2026 ONE-TIME ASSESSMENTS FOR NEW HEALTH ADVANCEMENT ADMINISTRATIVE COSTS

SECTION 3D.3.(a) For purposes of this section, the following definitions apply:

(1) Acute care hospital. – As defined in G.S. 108A-145.3.

(2) Aggregate collection amount. – Fourteen million three hundred thousand dollars ($14,300,000) minus intergovernmental transfer receipts.

(3) DHHS. – The Department of Health and Human Services.

(4) Hospital costs. – As defined in G.S. 108A-145.3.

(5) Intergovernmental transfer receipts. – The amount of money received during the quarter in which this section becomes effective by DHHS through intergovernmental transfers and that is designated in DHHS's accounting system as a receipt for the 2026 one-time assessments.

(6) Private acute care hospital. – As defined in G.S. 108A-145.3.

(7) Private hospital historical assessment share. – As defined in G.S. 108A-145.3.

(8) Public acute care hospital. – As defined in G.S. 108A-145.3.

(9) Public hospital historical assessment share. – As defined in G.S. 108A-145.3.

SECTION 3D.3.(b) Effective when this act becomes law, each private acute care hospital is subject to a 2026 one-time assessment that is a percentage of its hospital costs. The percentage shall equal the aggregate collection amount multiplied by the private hospital historical assessment share and divided by the total hospital costs for all private acute care hospitals.

SECTION 3D.3.(c) Effective when this act becomes law, each public acute care hospital is subject to a 2026 one-time assessment that is a percentage of its hospital costs. The percentage shall equal the aggregate collection amount multiplied by the public hospital historical assessment share and divided by the total hospital costs for all public acute care hospitals.

SECTION 3D.3.(d) The proceeds of the assessments under this section and intergovernmental transfer receipts shall be deposited in the Health Advancement Receipts Special Fund under G.S. 143C-9-10 and shall be used for the increased administrative costs described in Section 3D.1 of this act as allowed under G.S. 108A-147.13(a)(2). From the proceeds of this assessment and intergovernmental transfer receipts, DHHS shall use the sum of seven million eight hundred thousand dollars ($7,800,000) to provide funding to county departments of social services to support the counties with the increased administrative costs described in Section 3D.1 of this act.

SECTION 3D.3.(e) The hospital assessments under this section shall be imposed by DHHS in accordance with the following procedures:

(1) The assessment shall be calculated, imposed, and due in the time and manner prescribed by DHHS and shall be considered delinquent if not paid within seven calendar days of this due date.

(2) With respect to any hospital owing a past due assessment amount, DHHS may withhold the unpaid amount from Medicaid payments otherwise due or impose a late payment penalty. DHHS may waive a penalty for good cause shown.

(3) A hospital may appeal a determination of the assessment amount owed through a reconsideration review. The pendency of an appeal does not relieve a hospital from its obligation to pay an assessment amount when due.

(4) The assessment may be included as allowable costs of a hospital for purposes of any applicable Medicaid reimbursement formula, except the assessment shall be excluded from cost settlement.

(5) The assessment may not be added as a surtax or assessment on a patient's bill.

SECTION 3D.3.(f) For purposes of determining the aggregate amount of all assessments due from hospitals under Article 7B of Chapter 108A of the General Statutes pursuant to G.S. 108A-148.1(c)(2), the assessments under this section shall be considered an assessment due from hospitals under that Article.

SECTION 3D.3.(g) No later than February 1, 2027, DHHS shall submit to the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division a report that details the amount of the proceeds from the assessments imposed under this section that DHHS provided to each county department of social services and the date that those proceeds were provided to each county department of social services.

HOSPITAL HEALTH ADVANCEMENT ASSESSMENT FUNDING FOR NEW ADMINISTRATIVE COSTS

SECTION 3D.4.(a) G.S. 108A-147.7 reads as rewritten:

"**§ 108A-147.7. ~~Administration~~ Base administration component.**

(a) The base administration component is an amount of money that is calculated by adding the base State administration subcomponent calculated under subsection (b) of this section and the base county administration subcomponent calculated under subsection (c) of this section.

(b) ~~For each quarter of the 2023-2024 State fiscal year, the State administration subcomponent is the product of one million three hundred fifty thousand dollars ($1,350,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(24) is effective during any part of the month.~~ For each quarter of the 2024-2025 State fiscal year, the base State administration subcomponent is four million one hundred eighty-seven thousand seven hundred dollars ($4,187,700). For each subsequent State fiscal year, the base State administration subcomponent shall be increased over the prior year's quarterly amount by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year.

(c) ~~For each quarter of the 2022-2023 State fiscal year and the 2023-2024 State fiscal year, the county administration subcomponent is the product of one million six hundred sixty-seven thousand dollars ($1,667,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(24) is effective during any part of the month.~~ The base county administration subcomponent is ~~seven million four hundred thousand dollars ($7,400,000) for each quarter of the 2024-2025 State fiscal year and~~ seven million eight hundred thousand dollars ($7,800,000) for each quarter of the 2025-2026 State fiscal year. For each State fiscal year after the 2025-2026 State fiscal year, the base county administration subcomponent shall be increased over the prior year's quarterly amount by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year."

SECTION 3D.4.(b) Part 3 of Article 7B of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-147.7A. Supplemental administration component.**

(a) The supplemental administration component is an amount of money that is calculated by adding the supplemental State administration subcomponent calculated under subsection (b) of this section and the supplemental county administration subcomponent calculated under subsection (c) of this section.

(b) For the quarter of the 2026-2027 fiscal year beginning on July 1, 2026, the supplemental State administration subcomponent is zero. For the quarter of the 2026-2027 fiscal

year beginning on October 1, 2026, the supplemental State administration subcomponent is three million three hundred thousand dollars ($3,300,000). For the quarter of the 2026-2027 fiscal year beginning on January 1, 2027, the supplemental State administration subcomponent is two million three hundred fifty thousand dollars ($2,350,000). For the quarter of the 2026-2027 fiscal year beginning on April 1, 2027, the supplemental State administration subcomponent is three million three hundred thousand dollars ($3,300,000). For the 2027-2028 fiscal year, the quarterly supplemental State administration subcomponent shall be three million three hundred thousand dollars ($3,300,000) increased by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year. For each subsequent State fiscal year through the 2035-2036 State fiscal year, the supplemental State administration subcomponent shall be increased over the prior year's quarterly amount by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year. For each State fiscal year beginning on or after July 1, 2036, the supplemental State administration subcomponent quarterly amount is zero.

(c) For each quarter of the 2026-2027 fiscal year, the supplemental county administration component is seven million eight hundred thousand dollars ($7,800,000). For each subsequent State fiscal year through the 2035-2036 State fiscal year, the supplemental county administration subcomponent shall be increased over the prior year's quarterly amount by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year. For each State fiscal year beginning on or after July 1, 2036, the supplemental county administration subcomponent quarterly amount is zero."

SECTION 3D.4.(c) G.S. 108A-147.3, as amended by Section 6.1(n) of S.L. 2025-64, reads as rewritten:

"**§ 108A-147.3. Aggregate acute care hospital health advancement assessment collection amount.**

…

(b) The total nonfederal receipts for health advancement is an amount of money that is calculated quarterly by adding all of the following:

(1) The presumptive service cost component calculated under G.S. 108A-147.5.

(2) The health advancement acute care hospital HASP component calculated under G.S. 108A-147.6.

(2a) The health advancement freestanding psychiatric hospital HASP component calculated under G.S. 108A-147.6A.

(3) The base administration component calculated under G.S. 108A-147.7.

(3a) The supplemental administration component calculated under G.S. 108A-147.7A.

(4) The State retention component under G.S. 108A-147.9.

(5) The positive or negative health advancement reconciliation adjustment component calculated under G.S. 108A-147.11(a).

…."

SECTION 3D.4.(d) G.S. 108A-147.9 reads as rewritten:

"**§ 108A-147.9. Health advancement presumptive IGT adjustment component.**

…

(b) The public hospital health advancement IGT adjustment subcomponent is the total of the following amounts:

(1) Sixty percent (60%) of the public hospital share of the sum of the presumptive service cost component calculated under G.S. 108A-147.5 for the current quarter, the base administration component calculated under G.S. 108A-147.7

for the current quarter, the supplemental administration component calculated under G.S. 108A-147.7A, and the State retention component under G.S. 108A-147.8 for the current quarter. The public hospital share is the total hospital costs for all public acute care hospitals divided by the total hospital costs for all acute care hospitals except for critical access hospitals and rural emergency hospitals for the current quarter.

…

(c) The UNC Health Care System health advancement IGT adjustment subcomponent is the total of the following amounts:

(1) The UNC Health Care System share of the sum of the presumptive service cost component calculated under G.S. 108A-147.5 for the current ~~quarter and~~ quarter, the base administration component calculated under G.S. 108A-147.7 for the current ~~quarter.~~ quarter, and the supplemental administration component calculated under G.S. 108A-147.7A for the current quarter. The UNC Health Care System share is the total hospital costs for the UNC Health Care System hospitals divided by the total hospital costs for all acute care hospitals except for critical access hospitals and rural emergency hospitals for the current quarter.

…

(d) The East Carolina University health advancement IGT adjustment subcomponent is the total of the following amounts:

(1) The East Carolina University share of the sum of the presumptive service cost component calculated under G.S. 108A-147.5 for the current ~~quarter and~~ quarter, the base administration component calculated under G.S. 108A-147.7 for the current ~~quarter.~~ quarter, and the supplemental administration component calculated under G.S. 108A-147.7A for the current quarter. The East Carolina University share is the total hospital costs for the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine divided by the total hospital costs for all acute care hospitals except for critical access hospitals and rural emergency hospitals for the current quarter.

…."

SECTION 3D.4.(e) G.S. 108A-147.13 reads as rewritten:

"**§ 108A-147.13. Use of funds.**

…

(b) The Department shall use an amount of the proceeds of the health advancement assessments that is equal to the sum of the base county administration subcomponent of the base administration component in G.S. 108A-147.7 and the supplemental county administration subcomponent of the supplemental administration component in G.S. 108A-147.7A to provide funding to county departments of social services to support the counties in determining eligibility for newly eligible individuals.

(c) The amount of the proceeds of the health advancement assessments that may be used for administrative expenses attributable to providing Medicaid coverage to newly eligible individuals and administrative expenditures associated with the HASP program shall not exceed, for any State fiscal year, an amount equal to the sum of the base State administration subcomponent of the base administration component in G.S. 108A-147.7 for each quarter of the State fiscal year, the supplemental State administration subcomponent of the supplemental administration component in G.S. 108A-147.7A for each quarter of the State fiscal year, and all ~~corresponding~~ matching federal ~~funds.~~funds corresponding to those subcomponents.

…."

SECTION 3D.4.(f) This section is effective July 1, 2026, and applies to assessments imposed on or after that date.

ADMINISTRATIVE COST REPORTING AND RECONCILIATION

SECTION 3D.5. No later than October 1, 2029, the Department of Health and Human Services, Division of Health Benefits (DHB), shall submit a report to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid, and the Fiscal Research Division that includes all of the following:

(1) The estimated share of the actual administrative costs expended through June 30, 2029, by DHB that is attributable to compliance with the requirements described in Section 3D.1 of this act.

(2) A description of any reduction to the administrative costs described in Section 3D.1 of this act resulting from (i) actions taken by DHB to achieve efficiencies or (ii) decreases in enrollment in NC Health Works.

(3) The total amount of assessment receipts and intergovernmental transfer receipts from April 1, 2026, through June 30, 2029, that are attributable to G.S. 108A-147.7A or Section 3D.3 of this act.

(4) A proposal for crediting against future assessments owed under Article 7B of Chapter 108A of the General Statutes any amounts under subdivision (3) of this section that exceed the amount under subdivision (1) of this section.

(5) Any proposed legislative changes to ensure that hospital assessment and intergovernmental transfer amounts attributable to G.S. 108A-147.7A do not exceed the administrative costs expended to comply with the requirements described in Section 3D.1 of this act, including any of the following:

a. Adjustments to the supplemental administration component in G.S. 108A-147.7A.

b. Addition of a statutory annual reconciliation of any hospital assessment and intergovernmental transfer amounts attributable to G.S. 108A-147.7A in excess of actual administrative costs expended to comply with the requirements described in Section 3D.1 of this act.

REPORTING ON CERTAIN CHANGES RESULTING IN REDUCTION IN ADMINISTRATIVE COSTS

SECTION 3D.6.(a) If the Department of Health and Human Services, Division of Health Benefits (DHB), determines that the requirements described in Section 3D.1 of this act as applied to NC Health Works will be modified or eliminated due to a change in federal or State law, rule, or regulation and the modification or elimination will reduce the administrative costs described in Section 3D.1 of this act, then DHB shall submit a report on its determination to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid, and the Fiscal Research Division. This report shall be due 60 days after DHB identifies the anticipated modification or elimination and shall include all of the following:

(1) An explanation of the anticipated modification or elimination.

(2) The date the modification or elimination is expected to be effective.

(3) A fiscal analysis of the anticipated reduction in administrative costs attributable to the modification or elimination.

(4) A proposal for a decrease or elimination of the amounts included in the assessments to hospitals under G.S. 108A-147.7A that corresponds to the anticipated reduction in administrative costs.

SECTION 3D.6.(b) This section expires June 30, 2036.

END NEW HOSPITAL ASSESSMENT AMOUNTS UNDER CERTAIN CONDITIONS

SECTION 3D.7.(a) In developing the average commercial rate demonstration for the Healthcare Access and Stabilization Program (HASP), the Department of Health and Human Services, Division of Health Benefits (DHB), shall use the payment methodology or approach that produces the maximum allowable level of HASP reimbursements to hospitals and receives federal approval.

SECTION 3D.7.(b) DHB shall submit a report to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid, and the Fiscal Research Division if DHB determines that any of the following conditions have been met:

(1) Centers for Medicare and Medicaid Services (CMS) approved a HASP preprint that is less than ninety-five percent (95%) of the maximum allowable amount for HASP under federal law or regulation, calculated based on all of the following:
   a. Limits on state directed payments and provider taxes established under Public Law 119-21.
   b. Any federal laws or regulations related to state directed payments, provider taxes, and intergovernmental transfers that are applicable to the period for which the CMS approval is received.

(2) The gross HASP reimbursements to hospitals approved by CMS for a fiscal year are less than one billion five hundred million dollars ($1,500,000,000).

(3) The gross HASP reimbursements paid to hospitals, calculated on an accrual basis, for a fiscal year are less than one billion five hundred million dollars ($1,500,000,000).

(4) A change in federal law or regulation resulted in adjusted hospital intergovernmental transfers, in any quarter, that were at least twenty percent (20%) lower than the amount of base hospital intergovernmental transfers for that quarter. For purposes of this subdivision, the following definitions apply:
   a. Actual hospital intergovernmental transfers. – The sum of all intergovernmental transfers designated in DHHS's accounting system as either a receipt for health advancement or a receipt related to the modernized assessments.
   b. Adjusted hospital intergovernmental transfers. – The amount of the base hospital intergovernmental transfers adjusted to account for any new federal restrictions on intergovernmental transfers established through federal law or regulation.
   c. Base hospital intergovernmental transfers. – The sum of actual hospital intergovernmental transfers collected during the quarter of fiscal year 2025-2026 beginning on October 1, 2025, plus the amount of hospital assessments under Article 7B of Chapter 108A of the General Statutes collected in that quarter from public acute care hospitals, adjusted for any changes in hospital status that occurred after October 1, 2025.
   d. Changes in hospital status. – As defined in G.S. 108A-146.17.
   e. Public acute care hospital. – As defined in G.S. 108A-145.3.

SECTION 3D.7.(c) The report required by subsection (b) of this section is due 120 days after DHB's determination that one of the conditions has been met. Prior to submitting the report, DHB shall allow at least 30 days for the North Carolina Healthcare Association to review the determination and to provide written confirmation or disagreement with the determination.

Once a report required under subsection (b) of this section has been submitted, DHB shall not be required to submit any further reports under subsection (b) of this section.

SECTION 3D.7.(d) On the date DHB submits the report required by subsection (b) of this section, DHB shall notify, in writing, the Revisor of Statutes that the report has been submitted.

SECTION 3D.7.(e) G.S. 108A-147.7A, as enacted by Section 3D.4(b) of this act, reads as rewritten:

"**§ 108A-147.7A. Supplemental administration component.**

(a) The supplemental administration component is an amount of money that is calculated by adding the supplemental State administration subcomponent calculated under subsection (b) of this section and the supplemental county administration subcomponent calculated under subsection (c) of this section.

(b) ~~For the quarter of the 2026-2027 fiscal year beginning on July 1, 2026, the supplemental State administration subcomponent is zero. For the quarter of the 2026-2027 fiscal year beginning on October 1, 2026, the supplemental State administration subcomponent is three million three hundred thousand dollars ($3,300,000). For the quarter of the 2026-2027 fiscal year beginning on January 1, 2027, the supplemental State administration subcomponent is two million three hundred fifty thousand dollars ($2,350,000). For the quarter of the 2026-2027 fiscal year beginning on April 1, 2027, the supplemental State administration subcomponent is three million three hundred thousand dollars ($3,300,000). For quarter of the 2027-2028 fiscal year, the supplemental State administration subcomponent shall be three million three hundred thousand dollars ($3,300,000) increased by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year. For each subsequent State fiscal year through the 2035-2036 State fiscal year, the supplemental State administration subcomponent shall be increased over the prior year's quarterly amount by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year. For each State fiscal year beginning on or after July 1, 2036, the~~ The supplemental State administration subcomponent quarterly amount is zero.

(c) ~~For each quarter of the 2026-2027 fiscal year, the supplemental county administration component is seven million eight hundred thousand dollars ($7,800,000). For each subsequent State fiscal year through the 2035-2036 State fiscal year, the supplemental county administration subcomponent shall be increased over the prior year's quarterly amount by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year. For each State fiscal year beginning on or after July 1, 2036, the~~ The supplemental county administration subcomponent quarterly amount is zero."

SECTION 3D.7.(f) Section 3D.6 of this act is repealed.

SECTION 3D.7.(g) Subsections (e) and (f) of this section are effective on the first day of the next assessment quarter that is two years after the date the report required by subsection (b) of this section is submitted. Subsection (e) of this section applies to assessments imposed on or after the date subsection (e) of this section becomes effective.

SECTION 3D.7.(h) This section expires on July 1, 2034, if no report required by subsection (b) of this section has been submitted by that date.

REPORT ON OPTIONS FOR CONTINUED FUNDING AFTER JUNE 30, 2036

SECTION 3D.8. No later than October 1, 2031, the Department of Health and Human Services, Division of Health Benefits (DHB), shall submit a report, in consultation with relevant stakeholders, to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint

Legislative Oversight Committee on Medicaid, and the Fiscal Research Division outlining options for the continued funding of the increased administrative costs described in Section 3D.1 of this act after June 30, 2036.

PART III-E. DIVISION OF HEALTH SERVICE REGULATION

INCREASED BED CAPACITY FOR FACILITIES LICENSED TO PROVIDE A PROGRAM OF OVERNIGHT RESPITE SERVICES

SECTION 3E.1.(a) G.S. 131D-6.1(c) reads as rewritten:

"(c) The Medical Care Commission shall adopt rules governing the licensure of adult day care and adult day health facilities providing a program of overnight respite services in accordance with this section. The Medical Care Commission shall seek input from stakeholders before proposing rules for adoption as required by this subsection. The rules shall limit the provision of overnight respite services for each adult to (i) not more than 14 consecutive calendar days, and not more than 60 total calendar days, during a 365-day period or (ii) the amount of respite allowed under the North Carolina Innovations waiver or Community Alternatives Program for Disabled Adults (CAP/DA) waiver, as applicable. The rules shall include minimum requirements to ensure the health and safety of overnight respite participants. These requirements shall address all of the following:

…

(2) ~~Staffing.~~Minimum staffing requirements, which shall include at least all of the following:

a. Each facility shall have staff on duty to meet the needs of each participant.

b. In addition to the requirement established by sub-subdivision a. of this subdivision, each facility with a census of one to six participants shall have a minimum of one staff present and awake at the facility at all times who is qualified to administer medications and is trained to provide personal care and supervision to current participants.

c. In addition to the requirement established by sub-subdivision a. of this subdivision, each facility with a census of seven to 12 participants shall have a minimum of two staff present and awake at the facility at all times, at least one of whom is qualified to administer medications, and both of whom are trained to provide personal care and supervision to current participants.

d. Staff required by sub-subdivisions a. to c. of this subdivision shall not perform housekeeping or food service duties during any shift in which the staff has been assigned the responsibility of providing personal care and supervision to participants. The facility is required to have additional staff available at the facility to provide daily housekeeping and food service duties.

…

(8) Bed capacity limitations, which shall not exceed ~~six~~ 12 beds in each ~~adult day care program.~~facility licensed to provide a program of overnight respite services.

…."

SECTION 3E.1.(b) The Medical Care Commission may adopt emergency and temporary rules as necessary to implement the requirements and limitations of G.S. 131D-6.1(c), as amended by subsection (a) of this section.

SECTION 3E.1.(c) Subsection (b) of this section is effective when this section becomes law. The remainder of this section becomes effective July 1, 2026.

PART III-F. DIVISION OF SOCIAL SERVICES

LIMITATIONS ON SELF-ATTESTATION/COUNTING INCOME OF CERTAIN INELIGIBLE INDIVIDUALS

SECTION 3F.1. Part 5 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"**§ 108A-52.1. Limitations on self-attestation; counting income of certain ineligible individuals.**

(a) In no case shall self-attestation be used as the sole evidence that an applicant meets eligibility requirements for the food and nutrition services program unless otherwise required by federal law.

(b) The Department shall count all income and financial resources of an individual determined to be ineligible to participate in the food and nutrition services program under 7 U.S.C. § 2015(f) when determining eligibility and benefit allotment of the household of which the individual is a member. The Department shall not prorate or exclude the income or financial resources of the ineligible individual."

STUDY TO CENTRALIZE ALL SERVICES ADMINISTERED BY THE DIVISION OF SOCIAL SERVICES

SECTION 3F.2.(a) The Office of State Budget and Management (OSBM), in consultation with the Department of Health and Human Services (DHHS), shall develop and issue a request for proposal (RFP) by October 31, 2026, to contract with a third-party organization to examine the short- and long-term opportunities to improve the efficiency, accuracy, and cost-effectiveness of having the State DHHS administer all federally and State mandated social services. The contractor selected to conduct the study shall work with DHHS and stakeholders, including county departments of social services and other partners. The study, at a minimum, shall do each of the following:

(1) Examine the advantages and disadvantages regarding centralization of all federally and State mandated social services.
(2) Analyze workforce capacity and performance for those services.
(3) Examine the logistics of transitioning to a centralized model, including estimates of implementation and ongoing costs and financing mechanisms.
(4) Provide a recommendation for a phased implementation timeline.
(5) Identify best practices, including research on how other states have centralized or otherwise improved the delivery of social services.
(6) Outline any known risks associated with centralizing these services.
(7) Examine opportunities to improve data-sharing and coordination among systems and programs.

SECTION 3F.2.(b) By June 30, 2027, OSBM and DHHS shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid, Joint Legislative Commission on Governmental Operations, and the Fiscal Research Division containing findings and recommendations regarding centralizing the administration of all federally and State mandated social services within the State DHHS based on (i) the information compiled from the study required by subsection (a) of this section and (ii) any other information available to those agencies. The report shall also include all of the following specific information:

(1) An overview of the State's current Medicaid and Food and Nutrition Services (FNS) programs' eligibility determination and enrollment structures, including a review of DHHS's current administrative and operational

practices, compliance reports submitted to federal agency partners, relevant audit findings, and other oversight materials.

(2) An assessment of how Medicaid and FNS applications and renewals are processed.

(3) Identification of best practices, including research on how other states have improved their Medicaid and FNS eligibility determination systems.

SECTION 3F.2.(c) There is appropriated from the General Fund to the Office of State Budget and Management the sum of one million dollars ($1,000,000) in nonrecurring funds for the 2026-2027 fiscal year to contract with a third-party to conduct the study required by subsection (a) of this section.

SECTION 3F.2.(d) Subsection (c) of this section is effective July 1, 2026. The remainder of this section is effective when it becomes law.

PART IV. AGRICULTURE AND NATURAL AND ECONOMIC RESOURCES

MODIFY CERTAIN ECONOMIC DEVELOPMENT PROJECT FUNDS

SECTION 4.1. Section 2C.2 of S.L. 2025-89 reads as rewritten:

"**SECTION 2C.2.(a)** Provided the Economic Investment Committee (EIC) awards a Job Development Investment Grant for a qualifying transformative project for an airplane manufacturer in Guilford County, there is appropriated from the Stabilization and Inflation Reserve established in Section 2.2(q) of S.L. 2022-74 to the Department of Commerce (Department) the sum of one hundred eighteen million one hundred thousand dollars ($118,100,000) in nonrecurring funds for the 2025-2026 fiscal year to be allocated for acquisitions and improvements at the project site as provided in this section. For a term of years the Department, in its discretion, deems appropriate, a recipient to whom funds are allocated under this section that uses the funds, in whole or in part, to acquire or improve land (other than water and sewer improvements) may not (i) sell or otherwise encumber the land or improvement (other than utility and access easements and road rights-of-way) or (ii), absent the consent of the EIC, lease the land or improvement; any such lease must require the land or improvement to be used by the business for the purposes set out in the ~~agreement.~~agreement; provided, however, that, with the approval of the EIC, the business benefitted by the funds allocated under this section may encumber its interest, or grant security interests in its interest, in the land or improvements acquired or improved with such funds as collateral for financing obtained by the business to finance the project so long as such collateral does not include any interest of the business in the land or improvements for which funds are allocated under subdivision (5) or subdivision (6) of this subsection.

For purposes of this section, the definitions of G.S. 143B-437.51 apply and a "qualifying transformative project" is a transformative project for which the Department enters into a binding contract with the business that requires, over a period of time not to exceed the base period, that the business invests at least four billion five hundred million dollars ($4,500,000,000) in private funds or funds provided by federal or foreign governments or their respective departments, agencies, divisions, or units or both and creates at least 14,000 eligible positions with an average annual wage of at least eighty-nine thousand three hundred forty dollars ($89,340). The contract constitutes a continuing obligation of the State and the business benefitted by the funds allocated for improving the project site. The contract must (i) include all of the performance criteria, remedies, and other safeguards required by the Department to secure the State's benefit derived from improvements to the airport funded by this section and (ii) require the business to repay an appropriate, proportionate amount of costs incurred by the State, or reimbursement paid to the business, for improvement of the airport for any failure by the business to meet and maintain the applicable performance criteria on which the cost incurred or reimbursement paid was based. Provided the requirements of the contract continue to be met, it is the intent of the General

Assembly to appropriate the sum of one hundred thirty-three million nine hundred thousand dollars ($133,900,000) in nonrecurring funds for the 2026-2027 fiscal year and additional funds in future acts in the aggregate amount of one hundred ninety-eight million dollars ($198,000,000) over the following four succeeding fiscal years to support the qualifying transformative project. With respect to funds allocated to the Piedmont Triad Airport Authority (Authority), the Authority may contract for the design and construction using any delivery method it deems appropriate, and the Department shall pay the costs of the design and construction to the Authority or shall reimburse the Authority for the costs of the design and construction from the funds allocated under this subsection. If it deems it appropriate, the Authority may authorize, in writing, the business who operates the improvements to contract for the design and construction of the improvements, and the Department or the Authority, if delegated by the Department, shall pay the costs of the design and construction to the business or shall reimburse the business for the costs of the design and construction from the funds allocated under this subsection. For purposes of this subsection, neither the Authority nor the business shall be subject to the provisions of Article 3D of Chapter 143 of the General Statutes or Article 8 of Chapter 143 of the General Statutes.

The funds appropriated for the 2025-2026 fiscal year in this section shall be allocated to, and used, as follows:

(1) Fifteen million dollars ($15,000,000) to the Piedmont Triad Airport Authority (Authority) for the acquisition of up to 150 acres of land (i) needed at Piedmont Triad International Airport (Airport) (ii) to be owned by the Authority for the project. If funds allocated pursuant to this subdivision exceed the anticipated amount necessary for the purpose of this subdivision, the Department may reallocate the surplus for purposes authorized in subdivision (2) of this subsection.

(2) Forty-five million dollars ($45,000,000) to the Authority for site analysis, engineering, grading, site preparation, site work, and access road and taxiway construction not otherwise provided for in this section that is needed at the Airport for the project. If funds allocated pursuant to this subdivision exceed the anticipated amount necessary for the purposes of this subdivision, the Department may reallocate the surplus for the purpose authorized in subdivision (1) of this subsection.

(3) Seven million nine hundred thousand dollars ($7,900,000) to the Department of Transportation for roadwork needed at the airport for the project. Notwithstanding any other provision of law, the Department of Transportation is authorized to utilize Progressive Design Build, Construction Management General Contractor, or any other procurement methodology to contract for the delivery of improvements for which funds are provided in this subdivision.

(4) Five million dollars ($5,000,000) to the City of Greensboro for water and sewer infrastructure improvements needed to support the project.

(5) Ten million two hundred thousand dollars ($10,200,000) to the ~~Authority~~ Department, to be allocated to and administered by the Authority on behalf of the Department, for the following:

a. Renovation costs of, and capital improvements to, an existing airport hub to (i) render it suitable for the project and (ii) be owned by the Authority. If funds allocated pursuant to this sub-subdivision exceed the amount necessary for the purpose of this subdivision, the Department may reallocate the surplus for purposes authorized in subdivision (6) of this subsection.

b. Offsets for costs required by the Federal Aviation Administration.

(6) Thirty-five million dollars ($35,000,000) to the ~~Authority~~ Department, to be allocated to and administered by the Authority on behalf of the Department, for the following costs related to construction of a facility for manufacturing, research, and development to be owned by the Authority for the project: (i) costs for general conditions, construction administration, demolition, construction of the substructure and shell of the facility, infrastructure enhancements and upgrades, building services, and mechanical systems, (ii) contractor fees, ~~and~~ (iii) fees for permitting, inspections, insurance, and related administrative ~~costs.~~costs, and (iv) sidewalks and a pedestrian bridge connecting the facility to the airport hub. If funds allocated pursuant to this subdivision exceed the anticipated amount necessary for the purpose of this subdivision, the Department may reallocate the surplus for purposes authorized in sub-subdivision (5)a. of this subsection.

"**SECTION 2C.2.(b)** On September 1 of each year funds appropriated for the airport remain unexpended until all funds have been expended, the Department shall report on the use of such funds to the House of Representatives and the Senate committee or subcommittee responsible for base budget and appropriations, to the Joint Legislative Economic Development and Global Engagement Oversight Committee, to the Joint Legislative Commission on Governmental Operations, and to the Fiscal Research Division. The report shall include, at a minimum, an executive summary of the performance of the business; the performance criteria, remedies, and safeguards required by the Department for the funds; a description of the current status of the project; the amount that was paid in the prior fiscal year; the purpose for which the amount was paid; the total amount that has been paid; and any encumbrance allowed on the land or an improvement on the land, including any lease."

CLARIFY HERTFORD WATER INFRASTRUCTURE FUNDING

SECTION 4.2. Funds allocated to the Town of Hertford by Section 12.2(e)(82) of S.L. 2023-134 for water capacity increase may, notwithstanding that section, be used by the Town for any water or wastewater infrastructure project.

PART V. JUSTICE AND PUBLIC SAFETY

DEPARTMENT OF ADULT CORRECTION CRITICAL OPERATING NEEDS

SECTION 5.1. There is appropriated from the General Fund to the Department of Adult Correction the sum of eighty million dollars ($80,000,000) in nonrecurring funds for the 2025-2026 fiscal year to be used to address a shortfall in operating funds for the Department.

STATE BUREAU OF INVESTIGATION OPERATING NEEDS

SECTION 5.2. There is appropriated from the General Fund to the State Bureau of Investigation the sum of (i) two million five hundred thousand dollars ($2,500,000) in recurring funds beginning in the 2025-2026 fiscal year and (ii) one million two hundred thousand dollars ($1,200,000) in nonrecurring funds for the 2025-2026 fiscal year, to be used to address a shortfall in operating funds for the Bureau.

FUNDS TO CONTINUE CASE MANAGEMENT SYSTEM USED BY THE BUSINESS COURT

SECTION 5.3. There is appropriated from the General Fund to the Administrative Office of the Courts, Budget Fund 100064, the sum of one hundred sixty-five thousand dollars ($165,000) in nonrecurring funds for the 2025-2026 fiscal year to be used to extend the case management software used by the North Carolina Business Court that is in addition to the eCourts system.

PART VI. GENERAL GOVERNMENT

GENERAL ASSEMBLY OPERATING EXPENSES

SECTION 6.1. There is appropriated from the General Fund to the General Assembly the sum of one million five hundred thousand dollars ($1,500,000) in nonrecurring funds for the 2025-2026 fiscal year for operating expenses.

OFFICE OF STATE BUDGET AND MANAGEMENT DIRECTED GRANTS MODIFICATION

SECTION 6.2. Notwithstanding any provision of S.L. 2023-134, as amended, or the Committee Report referenced in Section 43.2 of that act to the contrary, the following directed grants allocated by the Office of State Budget and Management – Special Appropriations for the 2023-2024 fiscal year are amended as follows:

(1) Any remaining funds from the directed grant to the Mayland Community College Foundation, Inc., a nonprofit corporation, for two million dollars ($2,000,000) for the 2023-2024 fiscal year for the Avery-Mitchell animal shelter shall instead be granted in equal amounts to Avery and Mitchell Counties to be used for any public purpose that the counties are authorized by law to engage in.

(2) The directed grant to the Town of Selma for eight hundred thousand dollars ($800,000) for the 2023-2024 fiscal year for economic development project recruitment shall instead be allocated to Johnston County Economic Development Corporation, a nonprofit corporation, for the same purpose.

(3) The directed grant to Iredell County for five million dollars ($5,000,000) for the 2023-2024 fiscal year for capital improvements or equipment at the fairgrounds shall instead be allocated as follows:

a. Three million dollars ($3,000,000) to the Iredell County Sheriff's Office for a new safety building on Lake Norman.

b. Two million dollars ($2,000,000) to the City of Statesville for water and wastewater projects pertaining to economic development consistent with Section 12.2(e)(179) of S.L. 2023-134.

(4) The directed grant of one million six hundred thousand dollars ($1,600,000) for the 2023-2024 fiscal year to Harnett County for land acquisition or capital improvements related to Johnson Farm shall instead be used for renovations of existing parks, improvements in park safety and accessibility, and development of green spaces, trails, and greenways.

(5) Funds allocated to the Office of State Budget and Management by Section 12.2(f)(2) of S.L. 2023-134 to provide a grant to the Burke Partnership for Economic Development, Inc., a nonprofit corporation, to install water and wastewater at the Western NC Megasite and remaining unspent and unencumbered as of the effective date of this section, shall, notwithstanding that subdivision or any provision of law to the contrary, be reallocated to Burke County to be used for water and wastewater projects in Burke County.

PART VII. TRANSPORTATION

DIVISION OF MOTOR VEHICLES CRITICAL OPERATING NEEDS

SECTION 7.1.(a) There is appropriated from the Highway Fund to the Department of Transportation, Division of Motor Vehicles (DMV) the sum of thirteen million one hundred thousand dollars ($13,100,000) in recurring funds beginning with the 2025-2026 fiscal year and

the sum of eight million five hundred thousand dollars ($8,500,000) in nonrecurring funds in the 2025-2026 fiscal year to be used to address a shortfall in operating funds for the DMV caused by unrealized anticipated fee receipts related to credit card transactions.

SECTION 7.1.(b) The Office of State Budget and Management, in consultation with the DMV, shall align credit card receipt line items with actual collections. The DMV shall adjust credit card fee receipt collection projections in accordance with G.S. 143C-3-5(b)(2)c. and shall adjust Base Budget requirements to match those projected receipts.

PART VIII. MISCELLANEOUS

STATE BUDGET ACT APPLICABILITY

SECTION 8.1. If any provision of this act and G.S. 143C-5-4 are in conflict, the provisions of this act shall prevail. The appropriations and the authorizations to allocate and spend funds which are set out in this act shall remain in effect until the Current Operations Appropriations Act for the applicable fiscal year becomes law, at which time that act shall become effective and shall govern appropriations and expenditures. When the Current Operations Appropriations Act for that fiscal year becomes law, the Director of the Budget shall adjust allotments to give effect to that act from July 1 of the fiscal year.

PART IX. EFFECTIVE DATE

SECTION 9.1. Except as otherwise provided, this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 28th day of April, 2026.

s/ Phil Berger
President Pro Tempore of the Senate

s/ Destin Hall
Speaker of the House of Representatives

_____
Josh Stein
Governor

Approved _____.m. this _____ day of _____, 2026