HOUSE BILL 696: Medicaid & HHS Adjust./Other Critical Needs.

2025-2026 General Assembly

Committee:		**Date:**	April 22, 2026
Introduced by:	Reps. Potts, Reeder, Campbell	**Prepared by:**	LAD and BDD Staff
Analysis of:	Conference Committee Substitute (H696-CCSLUxr-3)		

OVERVIEW: The Conference Committee Substitute for House Bill 696 makes various changes to the Medicaid and SNAP programs, including changes necessary to comply with H.R.1. It also implements various budgetary adjustments and makes other changes to the budget operations of the State.

PART I. GENERAL PROVISIONS

SECTION 1.1 EXTENSION OF CERTAIN DIRECTED GRANTS

Extends to June 30, 2027, the date that certain grant funds revert, allowing additional time for completion of outstanding grant projects.

PART II. EDUCATION

SECTION 2.1 NORTH CAROLINA BLUE RIBBON COMMISSION ON PUBLIC EDUCATION

Establishes North Carolina Blue Ribbon Commission on Public Education and appropriates $300,000 in nonrecurring funds to the Friday Institute for Educational Innovation at NC State to administer the Commission.

SECTION 2.2 CONFORM ELIGIBLE EXPENSES FOR NORTH CAROLINA 529 PLAN TO FEDERAL LAW

Permits NC 529 accounts to be used for additional qualifying educational expenses added to the Internal Revenue Code in the One Big Beautiful Bill Act in 2025.

SECTION 2.3 FUNDS FOR RECIPIENTS OF THE CHILDREN OF WARTIME VETERANS SCHOLARSHIP IN THE 2025-2026 ACADEMIC YEAR

Provides $1 million to increase award amounts for 25-26 awardees of the Children of Wartime Veterans Scholarship to increase awards that were reduced for the Spring of 2026 due to a shortfall.

SECTION 2.4 FUNDS FOR ADDITIONAL AWARDS FOR THE CHILDREN OF WARTIME VETERANS SCHOLARSHIP IN THE 2026-2027 ACADEMIC YEAR

Raises the cap on Class II and Class III awards of the Children of Wartime Veterans Scholarship from 100 to 200 awardees for each class in 2026-2027, funds the higher cap, and provides additional funds to meet anticipated demand for awards in 2026-2027; and provides that this section is effective July 1, 2026.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

SECTION 2.5 EXPAND EXISTING FLEXIBILITY FOR THE CHILDREN OF WARTIME VETERANS SCHOLARSHIP FUNDS PROGRAM TO INCLUDE THE 2026-2027 ACADEMIC YEAR
Extends Children of Wartime Veterans scholarship award flexibility already provided to the Secretary of the Department of Military and Veterans Affairs through 2026-2027 and expands that flexibility to include the ability to prioritize undergraduate applications and establish a standardized payment schedule.

PART III. HEALTH AND HUMAN SERVICES

PART III-A. DEFINITIONS

SECTION 3A.1– Provides definitions applicable throughout the Part.

PART III-B. DIVISION OF CENTRAL MANAGEMENT AND SUPPORT

SECTION 3B.1 PERIODIC REPORTING ON THE NORTH CAROLINA RURAL HEALTH TRANSFORMATION PLAN
Requires quarterly reporting from the Department of Health and Human Services (DHHS) to the Joint Legislative Commission on Governmental Operations on the implementation status of the NC Rural Health Transformation Plan (NCRHTP). Report deadlines are set to align with the quarterly and annual reports due from DHHS to the Centers for Medicare and Medicaid Services (CMS) regarding the NCRHTP.

PART III-C. DIVISION OF HEALTH BENEFITS

SECTION 3C.1 DURATION OF MEDICAID PROGRAM MODIFICATIONS
Clarifies that, consistent with its authority over the Medicaid program, DHHS is only required to maintain any modifications to the Medicaid programs required by this part through June 30, 2027.

SECTION 3C.2 MEDICAID REBASE FUNDING
Appropriates $319M nonrecurring from the Medicaid Contingency Reserve for the Medicaid rebase for the 2025-2026 fiscal year.

SECTION 3C.3 LME/MCO INTERGOVERNMENTAL TRANSFERS
Provides authority requiring local management entity/managed care organizations (LME/MCOs) to make $18M in recurring intergovernmental transfers to the Division of Health Benefits for the current fiscal year.

SECTION 3C.4 TECHNICAL UPDATES TO COMPLY WITH H.R.1
Makes statutory changes to comply with new requirements of Public Law 119-21, also known as the "One Big Beautiful Bill Act." Subsection (a) of this section clarifies statutory language requiring individuals to comply with applicable community engagement requirements in order to be eligibility for NC Health Works. Subsections (b) and (c) of this section make technical updates to conform with federal law changes to the categories of immigrants that are eligible for Medicaid.

SECTION 3C.5 COMMUNITY ENGAGEMENT REQUIREMENTS
Requires DHHS to maintain, to the fullest extent allowable, work requirements as a condition of participation in the Medicaid program so long as work requirements may be authorized by the Centers for Medicare and Medicaid Services (CMS). This section also requires an applicant for Medicaid to provide

proof of compliance with community engagement requirements for three consecutive months immediately preceding initial application and proof of compliance with community engagement requirements for any three of the last six months at the time of redetermination.

SECTION 3C.6 MONTHLY DATA CHECKS
Amends the statute requiring DHHS to review information concerning changes in circumstances that may affect Medicaid eligibility to require that review to be done monthly, rather than quarterly. It also adds gambling winnings to the list of information that must be reviewed.

SECTION 3C.7 LIMIT USE OF SELF-ATTESTATION IN VERIFYING MEDICAID ELIGIBILITY
Prohibits DHHS or county departments of social services from accepting self-attestation as the only evidence in verification of Medicaid eligibility requirements, except as required by federal law.

SECTION 3C.8 HOUSEHOLD MEMBER INCOME INFORMATION
Requires the income of all household members, regardless of immigration status, to be considered when determining an applicant or beneficiary's Medicaid eligibility.

SECTION 3C.9 CONFIDENTIALITY OF RECORDS EXCEPTION
Requires DHHS to refer any applicant or beneficiary to the United States Department of Homeland Security if citizenship or satisfactory immigration status cannot be verified.

SECTION 3C.10 MEDICAID PROGRAM AND NCWORKS CAREER CENTERS AUDIT
Requires the State Auditor to conduct a performance audit of the administration of the Medicaid program and NCWorks Career Center and appropriates $500,000 nonrecurring for this purpose.

SECTION 3C.11 ANNUAL FRAUD, WASTE, AND ABUSE REPORTING
Requires DHHS to annually report to the Joint Legislative Oversight Committee on Medicaid on improper Medicaid payments that were determined to be fraud, waste, and abuse, recovered funds, and the percentage of improper payments that were investigated or reviewed.

SECTION 3C.12 PREPAID HEALTH PLAN PROVIDER NETWORKS
Authorizes PHPs to develop closed networks for designated service categories if an open network for that service category would jeopardize quality of care, program integrity, or cost effective use of Medicaid funds, subject to DHHS approval and a demonstration of ongoing network adequacy. DHHS has 180 days to respond to a PHP's request to close a network or the request is deemed approved.

SECTION 3C.13 PREPAYMENT CLAIMS REVIEW
Authorizes PHPs to place a provider on prepayment claims review without approval from DHHS, eliminates the 20-day notice period given to providers, increases the prepayment claims review compliance threshold in G.S. 108C-7 from 70% to 80%, eliminates the 24-month limit on how long a provider may remain on prepayment claims review, and allows PHPs to remove providers from their provider networks if the provider fails to meet the prepayment claims review thresholds, subject to DHHS approval. DHHS has 90 days to respond to a PHP's request to exclude a provider or the request is deemed approved.

SECTION 3C.14 PLAN FOR PROGRAM INTEGRITY AND EFFICIENCY
Requires DHHS to establish a plan for Medicaid program integrity and efficiency that includes (i) reduction of DHHS's administrative expenses, (ii) increased flexibilities for PHPs, (iii) alignment of rate schedules for inpatient services that could be provided in an outpatient setting, (iv) flexibilities for PHPs to manage utilization of GLP-1s, (v) improved alignment of PHP and Advanced Medical Home (AMH) contract incentives with cost containment efforts, (vi) improved reporting on AMH care management

activities, and (vii) improved network management tools for PHPs. This section requires DHHS to report on the plan by October 1, 2026, and implement the plan no earlier than July 1, 2027.

SECTION 3C.15 ALLOW CERTAIN PREPAID HEALTH PLAN PRACTICES
Requires that DHHS not prohibit PHPs from requiring itemized bills for certain inpatient hospital outlier claims.

SECTION 3C.16 COST SHARING
Requires DHHS to annually implement the highest allowable copays for all Medicaid services.

SECTION 3C.17 EXTEND DURABLE MEDICAL EQUIPMENT RATES IN MEDICAID MANAGED CARE
Extends until June 30, 2027, (was June 30, 2025) the requirement for standard plan PHPs to pay a rate for durable medical equipment (DME) that is 100% of the lesser of the supplier's usual and customary rate and the maximum allowable Medicaid fee-for-service rate for DME.

SECTION 3C.18 MEDICAID COVERAGE FOR ABA THERAPY
Requires DHHS to update Clinical Coverage Policy 8F to (i) prohibit services provided by a paraprofessional via telehealth, (ii) require patient assessments to be conducted in person, (iii) allow services involving the observation and direction of a paraprofessional to be conducted via telehealth and limits these telehealth services to no more than 50% of services provided to a beneficiary, (iv) require 10% of services provided by a paraprofessional be observed, (v) require licensed providers to develop individualized service plans for each beneficiary that include minimum requirements for caretaker involvement. Plans involving more than 16 hours of services a week are subject to approval, (vi) allow parent, guardian, and caregiver training to be provided via telehealth, (vii) exempt paraprofessionals from Medicaid credentialing, (vii) require paraprofessionals to be certified and allow a 120 day grace period for newly hired paraprofessionals, (ix) provide a minimum and maximum percentage of billed hours per patient provided by professionals as a percentage of services provided by a paraprofessional. DHHS may adopt exceptions to these requirements based upon medical necessity or access to care requirements. This section also requires professionals to be enrolled as in-State Medicaid providers.

PART III-D. HOSPITAL ASSESSMENT ADJUSTMENTS

Part III-D provides funding for the next 10 State fiscal years, in the form of increased total hospital receipts from hospital assessments and public hospital intergovernmental transfers, for the increased administrative costs of NC Health Works due to new community engagement (work) requirements and six-month eligibility redeterminations required by H.R.1. This part also requires certain reporting to the Joint Legislative Oversight Committee on Medicaid and would end the increased funding sooner than 10 years if certain conditions pertaining to hospital funding occur. For a more detailed explanation, *see Appendix A at the end of this Summary.*

PART III-E. DIVISION OF HEALTH SERVICE REGULATION

SECTION 3E.1 INCREASED BED CAPACITY FOR FACILITIES LICENSED TO PROVIDE A PROGRAM OF OVERNIGHT RESPITE SERVICES
Allows adult day care and adult day health facilities to increase their overnight bed capacity from 6 to 12 beds; and directs the Medical Care Commission to amend the rules governing staffing for overnight respite facilities to establish minimal requirements based on the number of program participants. Specifically:

- Facilities with 6 or fewer participants must have at least one staff member awake and on duty who is qualified to administer medications and trained to provide personal care and supervision to participants.
- Facilities with 7-12 participants must have at least two staff members awake and on duty, at least one of whom is qualified to administer medications, and both of whom are trained to provide personal care and supervision to participants.
- Prohibits the performance of housekeeping or food service duties by staff during any shift the staff is assigned to provide personal care and supervision to participants.

Subsection (b) authorizes the Medical Care Commission to adopt emergency and temporary rules to implement these updated minimum staffing requirements.

PART III-F. DIVISION OF SOCIAL SERVICES

SECTION 3F.1 LIMITATIONS ON SELF-ATTESTATION/COUNTING INCOME OF CERTAIN INELIGIBLE INDIVIDUALS

Limits self-attestation for purposes of satisfying eligibility requirements for federal Supplemental Nutrition Assistance Program (SNAP) benefits; and requires that all income of certain individuals determined ineligible for SNAP benefits be counted when determining eligibility and benefits for a household of which the individual is a member.

SECTION 3F.2 STUDY TO CENTRALIZE ALL SERVICES ADMINISTERED BY THE DIVISION OF SOCIAL SERVICES

Requires the Office of State Budget and Management, in consultation with the Department of Health and Human Services (DHHS), to develop and issue a request for proposal (RFP) by October 31, 2026, to contract with a third party to study whether the State DHHS should administer all federally and State mandated social services.

PART IV. AGRICULTURE AND NATURAL AND ECONOMIC RESOURCES

SECTION 4.1 MODIFY CERTAIN ECONOMIC DEVELOPMENT PROJECT FUNDS

Amends Section 2C.2 of S.L. 2025-89 to clarify that recipients of a Job Development Investment Grant awarded by the Economic Investment Committee (EIC) may encumber use their interest in land acquired with grant funds as collateral, provided EIC approves and the collateral was not acquired with funds that were allocated for improving an existing airport hub for the Piedmont Triad Authority or for the construction of a facility for manufacturing, research, and development to be owned by the Authority.

SECTION 4.2 CLARIFY HERTFORD WATER INFRASTRUCTURE FUNDING

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

PART V. JUSTICE AND PUBLIC SAFETY

SECTION 5.1 DEPARTMENT OF ADULT CORRECTION CRITICAL OPERATING NEEDS

Appropriates from the General Fund to the Department of Adult Correction $80 million in nonrecurring funds for the current fiscal year to use to address a shortfall in operating funds.

SECTION 5.2 STATE BUREAU OF INVESTIGATION OPERATING NEEDS

Appropriates from the General Fund to the State Bureau of Investigation for the current fiscal year $2.5 million in recurring funds and $1.2 million in nonrecurring funds to be used to address a shortfall in operating funds.

SECTION 5.3 FUNDS TO CONTINUE CASE MANAGEMENT SYSTEM USED BY THE BUSINESS COURT
Appropriates $165,000 in nonrecurring funds for the current fiscal year to the Administrative Office of the Courts to use to extend the case management system used by the North Carolina Business Court that is in addition to the eCourts system.

PART VI. GENERAL GOVERNMENT

SECTION 6.1 GENERAL ASSEMBLY OPERATING EXPENSES
Appropriates $1.5 million in nonrecurring funds for the 2025-2026 fiscal year to the General Assembly for operating expenses.

SECTION 6.2 OFFICE OF STATE BUDGET AND MANAGEMENT DIRECTED GRANTS MODIFICATION
Makes various adjustments to directed grants allocated to non-State entities from the 2023-2024 fiscal year.

PART VII. TRANSPORTATION

SECTION 7.1 DIVISION OF MOTOR VEHICLES CRITICAL OPERATING NEEDS
Appropriates from the Highway Fund to the Department of Transportation, Division of Motor Vehicles (DMV), for the current fiscal year $13.1 million in recurring funds and $8.5 million in nonrecurring funds to be used to address a shortfall in operating funds for the DMV caused by unrealized anticipated fee receipts related to credit card transactions. The section also directs the DMV to align credit cards receipt line items with actual collections.

PART VIII. MISCELLANEOUS

SECTION 8.1 STATE BUDGET ACT APPLICABILITY
Clarifies that if any provision of this act and G.S. 143C-5-4 are in conflict, the provisions of this act will prevail and provides that appropriations and authorizations to allocate and spend in this act remain in effect until the Current Operations Appropriations Act for the 2026-2027 fiscal year becomes law.

PART IX. EFFECTIVE DATE
SECTION 9.1 - Except as otherwise provided, makes this act effective when it becomes law.

APPENDIX A

Part III-D provides funding for the next 10 State fiscal years, in the form of increased total hospital receipts from hospital assessments and public hospital intergovernmental transfers, for the increased administrative costs of NC Health Works due to new community engagement (work) requirements and six-month eligibility redeterminations required by H.R.1. This Part also requires certain reporting to the Joint Legislative Oversight Committee on Medicaid and would end the increased funding sooner than 10 years if certain conditions pertaining to hospital funding occur.

Increased NC Health Works Administrative Costs

H.R. 1 requires states to implement work requirements and six-month eligibility redeterminations (currently 12-months) beginning January 1, 2027, for beneficiaries in the NC Health Works program. NC Health Works provides Medicaid coverage to individuals aged 18-64 with incomes up to 133% of the federal poverty level. In North Carolina, the State share of the estimated cost associated with implementing these new requirements is:

- $7.8 million nonrecurring for county administrative costs.
- $6.5 million nonrecurring for State administrative costs.
- $31.2 million recurring annually for county administrative costs, indexed annually.
- $13.2 million recurring annually for State administrative costs, indexed annually.

Hospital Assessment Funding

Under G.S. 108A-54.3B, all funding for NC Health Works costs must come from the following permissible sources:

- Hospital assessments.
- Hospital intergovernmental transfers (IGTs).
- Gross premiums tax increases due to the addition of NC Health Works coverage.
- Budgeted State savings to programs other than Medicaid due to the addition of NC Health Works.

Section 3D.1 establishes the General Assembly's intent to fund the increased administrative costs identified above from permissible funding sources. Sections 3D.3 and 3D.4 authorize new hospital assessment amounts to fund those costs for ten years.

Section 3D.3 creates a 2026 one-time assessment that is effective when it becomes law to be implemented on a timeline determined by the Department of Health and Human Services (DHHS) to collect the nonrecurring funding amounts needed for the 2025-2026 fiscal year.

Section 3D.4 amends the Hospital Health Advancement Assessments to differentiate historical, or "base," administrative costs from new, or "supplemental," administrative costs, and collects the recurring funding need through the supplemental administration component for the next 10 State fiscal years (ending July 1, 2036).

Role of Intergovernmental Transfers

H.R. 1 also prohibits states from increasing hospital provider assessments above the level in place as of July 4, 2025. In order to be able to collect the new hospital assessment amounts authorized in this Part without impermissibly increasing hospital assessments, hospitals would provide increased funding through IGTs in order to reduce the amount of assessment needed to fund historical obligations. Under current law, hospitals pay assessments that fund enhanced Medicaid reimbursements for hospital services, as well as other costs of the Medicaid program. A statutory formula determines the total amount of assessments to be collected and splits that total amount into a share paid by public hospitals and a share paid by private hospitals. The share paid by public hospitals is less than the share paid by private hospitals because public hospitals contribute additional funding through IGTs. Beginning in the 2026-2027 fiscal

year, public hospitals would begin providing an increased amount of funding through IGTs that is equal to the amount of assessments they currently pay under the statutory formula. **Section 3D.2** adjusts the statutory formula to presume these additional IGTs will be collected and reduces the amount of public hospital assessments to zero. If IGTs are not received as presumed, the uncollected IGT amount would be collected as a public hospital assessment in the following fiscal quarter.

HASP Impact

An additional feature of the use of increased IGTs as a funding source is that it would help maximize the enhanced reimbursements to hospitals that are currently funded through hospital assessments, particularly directed payments to hospitals through the Healthcare Access and Stabilization Program (HASP). G.S. 108A-148.1(c)(2) currently requires HASP payments to be reduced if necessary to keep total hospital assessments within federal limits. By increasing the share of HASP that is funded through IGTs as opposed to assessments, the less that HASP payments would need to be reduced due to federal limits.

Other Provisions

Section 3D.5 requires the Department of Health and Human Services (DHHS) to submit a report by October 1, 2029, comparing the actual new Medicaid administrative costs expended through June 30, 2029 to comply with H.R. 1 with the amount of increased funding provided by hospitals under Sections 3D.3 and 3D.4. The report would also contain legislative proposals for (i) crediting hospitals for any past overcollections, (ii) making appropriate adjustments to the administrative cost components of statutory assessment formulas, and (iii) adding an annual reconciliation feature to the statutory assessment formulas for future overcollections.

Section 3D.6 requires DHHS to report certain information if there are changes to work requirements or 6-month redetermination requirements that are expected to reduce the associated administrative costs. The report would explain the policy change, the fiscal impact of the policy change, and a proposal for making appropriate adjustments to the administrative cost components of statutory assessment formulas.

Section 3D.7 creates a trigger ending the new assessment funding added in Section 3D.4 two years after DHHS determines any one of the following conditions related to hospital funding are met:

(1) The HASP payments approved by CMS for a fiscal year are less than 95% of the legal maximum applicable to HASP payments.

(2) The gross HASP payments approved by CMS for a fiscal year are less than $1.5 billion.

(3) The gross HASP payments made to hospitals for a fiscal year are less than $1.5 billion.

(4) The legal restrictions on IGTs result in a relative decrease in IGTs of at least 20% based on calculations described in the legislation.

Section 3D.8 requires DHHS to report, by October 1, 2031, options for continued funding of the new administrative costs after June 30, 2036, when the new assessment funding added by Section 3D.4 sunsets.