2025-2026 General Assembly

HOUSE BILL 696: Medicaid & Health and Human Services Adjustments/Other Critical Needs, Part III: Health and Human Services

Analysis of: S.L. 2026-1, Part III

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Part III of S.L. 2026-1 (House Bill 696) does the following:

- Definitions: This part defines the terms "CMS," "NC RHTP," "Public Law 119-21," "RHTP or Rural Health Transformation Program," "SNAP," and "Subrecipient."
- Periodic Reporting on the North Carolina Rural Health Transformation Plan (NC RHTP): This part 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 RHTP. 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 NC RHTP.
- Division of Health Benefits: This part implements various budgetary adjustments and makes other various changes to the Medicaid program administered by DHHS, Division of Health Benefits (DHB), as follows:
    - Appropriates $319 million in nonrecurring funds from the Medicaid Contingency Reserve for the Medicaid rebase for the 2025-2026 fiscal year.
    - Provides authority requiring local management entity/managed care organizations (LME/MCOs) to make $18 million in recurring intergovernmental transfers to DHB for each fiscal year of the 2025-2026 fiscal biennium.
    - Makes changes to the statutes establishing Medicaid eligibility categories and income thresholds and the enrollment of eligible individuals in Medicaid managed care to comply with new requirements of Public Law 119-21, also known as the "One Big Beautiful Bill Act" and "H.R. 1" (H.R. 1). The changes (i) clarify statutory language requiring individuals to comply with applicable community engagement (work) requirements in order to be eligible for NC Health Works Medicaid coverage and (ii) make technical updates to conform with federal law changes to the categories of immigrants that are eligible for Medicaid.
    - Adds a statute requiring that DHHS must 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 CMS, and that Medicaid applicants must provide proof of compliance with work requirements for three consecutive months immediately preceding initial application and any three of the six months immediately preceding the date of eligibility redetermination.
    - Amends the statute requiring DHHS to review information concerning changes in circumstances that may affect Medicaid eligibility, to direct that review to be done

monthly, rather than quarterly. Gambling winnings are added to the list of information that must be reviewed. This statute subsequently was amended in Section 9E.20 of S.L. 2026-41 to restore quarterly review of information on earned income, unearned income, and financial resources.

- Adds a statute prohibiting 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.
- Adds a statutory requirement that the income of all household members, regardless of immigration status, must be considered when determining an applicant or beneficiary's Medicaid eligibility.
- Amends the statute establishing the confidentiality of records pertaining to applicants for public assistance to add a requirement that DHHS must refer any applicant or beneficiary to the United States Department of Homeland Security if citizenship or satisfactory immigration status cannot be verified.
- Requires the State Auditor to conduct a performance audit of the administration of the Medicaid program and NCWorks Career Center and appropriates $500,000 in nonrecurring funds for this purpose.
- Adds a statute requiring DHHS to annually report to the Joint Legislative Oversight Committee on Medicaid (JLOCM) on (i) improper Medicaid payments that were determined to be fraud, waste, and abuse, (ii) recovered funds, and (iii) the percentage of improper payments that were investigated or reviewed.
- Amends the statute pertaining to Medicaid prepaid health plan (PHP) provider networks, and makes other conforming statutory changes, to authorize 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.
- Amends the statute pertaining to policies requiring prepayment review of claims submitted by Medicaid providers to (i) authorize PHPs to place a provider on prepayment claims review without approval from DHHS, (ii) eliminate the 20-day notice period given to providers, (iii) increase the prepayment claims review compliance threshold from 70% to 80%, (iv) eliminate the 24-month limit on how long a provider may remain on prepayment claims review, and (v) allow 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.
- 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 to manage service utilization, costs, and claims, (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-1 drugs, (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 to the JLOCM and the Fiscal Research Division on the plan by October 1, 2026, and implement the plan no earlier than July 1, 2027.

- Amends the statute pertaining to the role of DHHS in Medicaid managed care to require that DHHS not prohibit PHPs from requiring itemized bills for certain inpatient hospital outlier claims.
- Adds a statute requiring DHHS to annually implement the highest allowable copayments for all Medicaid services. This statute subsequently was amended by Section 3.1 of S.L. 2026-42 to clarify that this requirement does not apply to dialysis services, Innovations waiver services, or Traumatic Brain Injury waiver services.
- 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.
- Requires DHHS to update Medicaid Clinical Coverage Policy 8F (Research-Based Behavioral Health Treatment for Autism Spectrum Disorder) 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, while limiting 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 by a licensed provider, (v) require licensed providers to develop individualized service plans for each beneficiary that include minimum requirements for caretaker involvement, (vi) require individualized service plans involving more than 16 hours of services a week to be approved by a PHP or DHHS, (vii) allow parent, guardian, and caregiver training to be provided via telehealth, (viii) exempt paraprofessionals from Medicaid credentialing, (ix) require paraprofessionals to be certified and allow a 120 day grace period for newly hired paraprofessionals, (x) 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 relevant professionals to be enrolled as in-State Medicaid providers.
- Clarifies that, for any modifications to the Medicaid programs in this part that are not statutory, DHHS is only required to maintain those modifications through June 30, 2027, consistent with DHHS's statutory authority over the Medicaid program.

- Hospital Assessment Adjustments: This part provides funding to DHB for the next 10 State fiscal years, in the form of increased total receipts from amounts paid by hospitals through 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 JLOCM and will end the increased funding sooner than 10 years if certain conditions pertaining to hospital funding occur.
- Division of Health Service Regulation: This part 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 minimum 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.
- Performance of housekeeping or food service duties by staff during any shift the staff is assigned to provide personal care and supervision to participants is prohibited.

- Division of Social Services: This part does the does the following:
  - Prohibits applicants from receiving SNAP benefits based solely on self-attestation of eligibility requirements unless expressly required by federal law. Eligibility must also be based on the income of all household members. The income and resources of all household members must be counted in determining eligibility, even if those members are themselves ineligible.
  - Requires a third party to study centralization of administration of all federally and State mandated social services. It also allocates $1 million in nonrecurring funds for the 2026-2027 fiscal year to fund the study. The report must be submitted to Joint Legislative Oversight Committee on Health and Human Services, the JLOCM, the Joint Legislative Commission on Governmental Operations, and the Fiscal Research Division by June 30, 2027.

The effective dates of this part are as follows:

- On July 1, 2025, the Medicaid rebase funding, the LME/MCO intergovernmental transfers to DHB, and the Medicaid DME managed care rate extension became effective retroactively.
- On July 1, 2026, the funding to the State Auditor for the Medicaid program performance audit, certain increased Medicaid receipts from hospitals, the Division of Health Service Regulation provisions, and the Division of Social Services funding became effective.
- On October 1, 2026, the Medicaid eligibility law changes pertaining to information about beneficiaries' changes in circumstance, limitations on the acceptance of self-attestation to verify eligibility, and immigrant eligibility, the referral requirement when citizenship or satisfactory immigration status of public assistance applicants cannot be verified, as well as certain increased Medicaid receipts from hospitals become effective.
- On January 1, 2027, the requirement for DHHS to maintain work requirements to the fullest extent allowable becomes effective.
- July 1, 2027, the requirement for DHHS to annually implement the highest Medicaid copayment becomes effective.
- Except as otherwise provided, this part became effective April 30, 2026.