GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2023

HOUSE BILL 76
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Short Title:	Access to Healthcare Options.	(Public)
Sponsors:	Representatives Lambeth, White, Wray, and Humphrey (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Finance, if favorable, Rules, Calendar, and Operations of the House	

February 9, 2023

A BILL TO BE ENTITLED

AN ACT TO PROVIDE NORTH CAROLINA CITIZENS WITH GREATER ACCESS TO HEALTHCARE OPTIONS.

Whereas, there are many North Carolina citizens who have no healthcare access; and

Whereas, the North Carolina model addressing this coverage gap will be paid for with a combination of intergovernmental transfers, hospital assessments, gross premiums tax revenue, and federal funds; and

Whereas, the North Carolina model addressing this coverage gap will not add to the national debt; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. MEDICAID AND HASP

MEDICAID

SECTION 1.1.(a) Effective January 1, 2024, Section 3 of S.L. 2013-5 is repealed.

SECTION 1.1.(b) Effective January 1, 2024, G.S. 108A-54.3A is amended by adding a new subdivision to read:

"(24) Individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. 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 1.1.(c) To promote health and wellness, the Department of Health and Human Services (DHHS) shall establish preventive care and wellness incentives for individuals eligible for Medicaid coverage under G.S. 108A-54.3A(24), as enacted by subsection (b) of this section. This includes incentives for preventive care and wellness activities such as health risk assessments, routine physicals, immunizations, routine screenings including mammograms and colonoscopies, and medically appropriate weight management programs. DHHS shall take into consideration the methods and types of incentives utilized by other states for this population, including Indiana and Michigan. Prepaid health plans are encouraged to offer preventive care and wellness incentives to their enrollees.

SECTION 1.1.(d) DHHS and all county departments of social services shall begin accepting applications from, and enrolling if permissible by the Centers for Medicare and Medicaid Services, individuals who will be eligible for Medicaid coverage under

G.S. 108A-54.3A(24), as enacted by subsection (b) of this section, as soon as practicable but not later than December 1, 2023.

SECTION 1.2.(a) Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding two new sections to read:

"**§ 108A-54.3B. Nonfederal share of NC Health Works costs.**

(a) As used in this section, the following definitions apply:

(1) Cost. – All expenses incurred by the State and counties that are eligible for Medicaid federal financial participation.

(2) NC Health Works. – The provision of Medicaid coverage to the individuals described in G.S. 108A-54.3A(24).

(b) It is the intent of the General Assembly to fully fund the nonfederal share of the cost of NC Health Works through a combination of the following sources:

(1) Increases in revenue from the gross premiums tax under G.S. 105-228.5 due to NC Health Works.

(2) Excluding any State retention, the increases in intergovernmental transfers due to NC Health Works.

(3) Excluding any State retention, the hospital health advancement assessments under Part 3 of Article 7B of Chapter 108A of the General Statutes.

(4) Savings to the State attributable to NC Health Works that correspond to State General Fund budget reductions to other State programs.

(c) By February 1 of each year, beginning in 2025, the Department shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Office of State Budget and Management, and the Fiscal Research Division containing all of the following information with supporting calculations:

(1) The total nonfederal share of the cost of NC Health Works for the preceding State fiscal year and the total funding available from the sources described in subsection (b) of this section.

(2) The projected total nonfederal share of the cost of NC Health Works for the current State fiscal year and the total projected funding available from the sources described in subsection (b) of this section.

(3) The method used by the Department to determine the amount of the health advancement assessments proceeds that were distributed to each county department of social services in compliance with G.S. 108A-147.13(b) for the preceding fiscal year, including the total amount of proceeds each county received in that fiscal year.

(4) The savings and benefits to the State resulting from NC Health Works for the preceding fiscal year, including savings to various State agencies and programs.

The Department shall submit detailed data supporting any calculations contained in the report to the Fiscal Research Division.

(d) If, for any fiscal year, the nonfederal share of the cost of NC Health Works cannot be fully funded through the sources described in subsection (b) of this section, then Medicaid coverage for the category of individuals described in G.S. 108A-54.3A(24) shall be discontinued as expeditiously as possible. Upon a determination by the Secretary that the nonfederal share of the cost of NC Health Works exceeds the funding from the sources described in subsection (b) of this section, the Secretary shall promptly do all of the following:

(1) Notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Office of State Budget and Management, and the Fiscal Research Division of the determination and post this notice on the Department's website. The notice must include the proposed effective date of the discontinuation of coverage.

(2) Submit all documents to the Centers for Medicare and Medicaid Services necessary to discontinue Medicaid coverage for the category of individuals described in G.S. 108A-54.3A(24).

"**§ 108A-54.3C. NC Health Works federal financial participation.**

If the federal medical assistance percentage for Medicaid coverage provided to the category of individuals described in G.S. 108A-54.3A(24) falls below ninety percent (90%), then Medicaid coverage for this category of individuals shall be discontinued as expeditiously as possible but no earlier than the date the lower federal medical assistance percentage takes effect. Upon receipt of information indicating that the federal medical assistance percentage will be lower than ninety percent (90%), the Secretary shall promptly do all of the following:

(1) Notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Office of State Budget and Management, and the Fiscal Research Division of the determination and post this notice on the Department's website. The notice must include the proposed effective date of the discontinuation of coverage.

(2) Submit all documents to the Centers for Medicare and Medicaid Services necessary to discontinue Medicaid coverage for the category of individuals described in G.S. 108A-54.3A(24)."

SECTION 1.2.(b) This section becomes effective January 1, 2024.

ARPA TEMPORARY SAVINGS FUND

SECTION 1.3.(a) The ARPA Temporary Savings Fund is established as a nonreverting special fund in the Department of Health and Human Services, Division of Health Benefits (DHB). The ARPA Temporary Savings Fund shall consist of any savings realized by DHB as a result of federal receipts arising from the enhanced federal medical assistance percentage (FMAP) available to the State under section 9814 of the American Rescue Plan Act of 2021, P.L. 117-2 (ARPA). Upon receipt by DHB of any federal receipts arising from that enhanced FMAP, DHB is directed to deposit the savings associated with those receipts into the ARPA Temporary Savings Fund. Funds in the ARPA Temporary Savings Fund may be allocated or expended only upon an act of appropriation by the General Assembly.

SECTION 1.3.(b) This section expires 10 years after the date this act becomes law.

HEALTHCARE ACCESS AND STABILIZATION PROGRAM (HASP)

SECTION 1.4. Article 7B of Chapter 108A of the General Statutes is amended by adding a new Part to read:

"Part 4. Healthcare Access and Stabilization Program.

"**§ 108A-148.1. Healthcare access and stabilization program.**

(a) The healthcare access and stabilization program is a directed payment program that provides acute care hospitals with increased reimbursements funded through hospital assessments in accordance with this section.

(b) The Department shall submit a 42 C.F.R. § 438.6(c) preprint requesting approval for the HASP program that includes any required demonstration for the financing of the nonfederal share of the HASP program costs. The Department shall not make any HASP directed payments prior to CMS approval of the initial preprint. The Department may not request any date of service for claims eligible for reimbursement through the HASP program earlier than July 1, 2022. The Department shall continue to submit any necessary documentation requesting continued approval for the HASP program as described in this section in the time and manner as required by CMS.

(c) All State funds required to make HASP directed payments shall be derived from HASP components of the hospital assessments under this Article, subject to all of the following limitations:

(1) If the Department determines that the HASP components under this Article will not generate funds in an amount equal to or greater than the total State funds required to make all HASP directed payments in any given quarter of the State fiscal year, then the Department shall reduce the amount of the HASP directed payments in the lowest amount necessary to ensure that the HASP components under this Article will generate enough funds to equal the total State funds required to make all the HASP directed payments in that quarter.

(2) If the aggregate amount of all assessments due from hospitals under this Article are determined by the Department to exceed the permissible limit established under 42 C.F.R. § 433.68(f) in any quarter of the State fiscal year, then the Department shall reduce the amount of the HASP directed payments in the lowest amount necessary to ensure that these hospital assessments in aggregate do not exceed the permissible limit.

(d) As part of the preprint submission required under this section, for the 2022-2023 State fiscal year, the Department shall not request any amount of HASP hospital reimbursements that is greater than the maximum amount allowable under 42 C.F.R. § 438.6(c). Beginning with the 2023-2024 State fiscal year, the Department shall not request any amount of HASP hospital reimbursements that is (i) greater than the maximum amount allowable under 42 C.F.R. § 438.6(c) or (ii) less than an annual estimated total dollar amount of three billion two hundred million dollars ($3,200,000,000) for services provided to not newly eligible individuals."

ASSESSMENTS FOR HEALTH ADVANCEMENT AND THE HASP PROGRAM

SECTION 1.5.(a) For purposes of this section, the following terms have the same definition as in G.S. 108A-145.3: acute care hospital, critical access hospital, and hospital costs. For the State fiscal quarter beginning October 1, 2023, each acute care hospital, except for critical access hospitals, is subject to an assessment of a percentage of its hospital costs. This hospital assessment shall be imposed by the Department of Health and Human Services (DHHS) in accordance with the procedures for hospital assessments under Part 1 of Article 7B of Chapter 108A of the General Statutes. DHHS shall calculate the hospital assessment percentage by dividing twelve million eight hundred thousand dollars ($12,800,000) by the total hospital costs for all acute care hospitals except for critical access hospitals. From the proceeds of this assessment, the DHHS shall use the sum of four million dollars ($4,000,000) to provide funding to county departments of social services to support the counties in preparing to implement Section 1.1 of this act.

SECTION 1.5.(b) No later than March 1, 2024, DHHS shall submit to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division a report that details the amount of the proceeds from the assessment imposed in accordance with subsection (a) of 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.

SECTION 1.5.(c) Subsection (a) of this section expires December 31, 2023.

SECTION 1.6.(a) G.S. 108A-145.3 reads as rewritten:

"**§ 108A-145.3. Definitions.**

The following definitions apply in this Article:

(1a) Actual nonfederal expenditures. – The nonfederal share for newly eligible individuals multiplied by the amount of the Medicaid assistance payment expenditures attributable to newly eligible individuals, inclusive of any adjustments, reported by the Department to CMS on the Form CMS-64.

~~(1)~~(1b) Acute care hospital. – A hospital licensed in North Carolina that is not a freestanding psychiatric hospital, a freestanding rehabilitation hospital, a long-term care hospital, or a State-owned and State-operated hospital.

…

(4a) Consumer Price Index: All Urban Consumers. – The most recent Consumer Price Index for All Urban Consumers for the South Region published by the Bureau of Labor Statistics of the United States Department of Labor available on March 1 of the previous State fiscal year.

(4b) Consumer Price Index: Medical Care. – The most recent Consumer Price Index for All Urban Consumers for Medical Care, U.S. city average, seasonally adjusted, published by the Bureau of Labor Statistics of the United States Department of Labor.

…

(5a) Current quarter. – The State fiscal quarter for which the assessment is being calculated.

(6) FMAP. – Federal medical assistance ~~percentage (FMAP).~~ percentage.

(6a) FMAP for newly eligible individuals. – The FMAP specified in 42 U.S.C. § 1396d(y)(1), expressed as a decimal.

(6b) FMAP for not newly eligible individuals. – The federal share of North Carolina Medicaid service costs as calculated by the federal Department of Health and Human Services in accordance with section 1905(b) of the Social Security Act, in effect at the start of the applicable assessment quarter, expressed as a decimal.

(6c) HASP directed payments. – Payments made by the Department to prepaid health plans to be used for (i) increased reimbursements to hospitals under the HASP program and (ii) the costs to prepaid health plans from the gross premiums tax under G.S. 105-228.5 and the insurance regulatory charge under G.S. 58-6-25 associated with those hospital reimbursements.

(6d) Healthcare access and stabilization program (HASP). – The directed payment program providing increased reimbursements to acute care hospitals approved by CMS and authorized by G.S. 108A-148.1.

…

(7a) IGT. – Intergovernmental transfer.

…

(12b) Newly eligible individual. – As defined in 42 C.F.R. § 433.204.

(12c) Nonfederal share for newly eligible individuals. – One minus the FMAP for newly eligible individuals.

(12d) Nonfederal share for not newly eligible individuals. – One minus the FMAP for not newly eligible individuals.

…."

SECTION 1.6.(b) Article 7B of Chapter 108A of the General Statutes is amended by adding a new Part to read:

"Part 3. Health Advancement Assessments.

"**§ 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 percentage for each quarter shall equal the aggregate 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.

"**§ 108A-147.2. Private hospital health advancement assessment.**

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

(b) The private hospital health advancement assessment shall be assessed as a percentage of each private acute care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department in accordance with this Part. The percentage for each quarter shall equal the aggregate health advancement assessment collection amount calculated under G.S. 108A-147.3 multiplied by the private hospital historical assessment share and divided by the total hospital costs for all private acute care hospitals holding a license on the first day of the assessment quarter.

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

(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, and (iii) subtracting the positive or negative IGT share of the reconciliation adjustment component calculated under G.S. 108A-147.11(b).

(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 HASP health advancement component calculated under G.S. 108A-147.6.

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

(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).

"**§ 108A-147.4.** Reserved for future codification purposes.

"**§ 108A-147.5. Presumptive service cost component.**

(a) For the State fiscal quarter beginning January 1, 2024, the presumptive service cost component is one hundred forty-six million two hundred fifty thousand dollars ($146,250,000).

(b) For each State fiscal quarter beginning on or after April 1, 2024, the presumptive service cost component is an amount of money that is the greatest of the following:

(1) The prior quarter's presumptive service cost component amount.

(2) The prior quarter's presumptive service cost component amount increased by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: Medical Care for the most recent three months available on the first day of the current quarter.

(3) The prior quarter's presumptive service cost component amount increased by the percentage change in the weighted average of the base capitation rates for standard benefit plans for all rating groups associated with newly eligible individuals compared to the prior quarter. The weight for each rating group shall be calculated using member months documented in the Medicaid managed care capitation rate certification for standard benefit plans.

(4) The prior quarter's presumptive service cost component amount increased by the percentage change in the weighted average of the base capitation rates for BH IDD tailored plans for all rating groups associated with newly eligible individuals compared to the prior quarter. The weight for each rating group shall be calculated using member months documented in the Medicaid managed care capitation rate certification for BH IDD tailored plans.

(5) The amount produced from multiplying 1.15 by the highest amount produced when calculating, for each quarter that is at least two and not more than five

quarters prior to the current quarter, the actual nonfederal expenditures for the applicable quarter minus the HASP health advancement component calculated under G.S. 108A-147.6 for the applicable quarter.

"**§ 108A-147.6. HASP health advancement component.**

The HASP health advancement component is an amount of money that is calculated by multiplying the aggregate amount of HASP directed payments due to PHPs in the current quarter for hospital reimbursements attributable to newly eligible individuals by the nonfederal share for newly eligible individuals.

"**§ 108A-147.7. Administration component.**

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

(b) The State administration subcomponent is three million three hundred thousand dollars ($3,300,000) for each quarter of the 2023-2024 State fiscal year. For each subsequent State fiscal year, the State administration subcomponent shall be increased over the prior year's quarterly amount by the Consumer Price Index: All Urban Consumers.

(c) The county administration subcomponent is five million dollars ($5,000,000) for each quarter of the 2023-2024 State fiscal year, 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 county administration subcomponent shall be increased over the prior year's quarterly amount by the Consumer Price Index: All Urban Consumers.

"**§ 108A-147.8. State retention component.**

The State retention component is ten million seven hundred fifty thousand dollars ($10,750,000) for each assessment quarter.

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

(a) The health advancement presumptive IGT adjustment component is an amount of money calculated by adding the public hospital health advancement IGT adjustment subcomponent calculated under subsection (b) of this section, the UNC Health Care System health advancement IGT adjustment subcomponent calculated under subsection (c) of this section, and the East Carolina University health advancement IGT adjustment subcomponent calculated under subsection (d) of this section.

(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 administration component calculated under G.S. 108A-147.7 for the current quarter, 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 for the current quarter.

(2) Sixty percent (60%) of the nonfederal share for newly eligible individuals of the aggregate amount of the HASP directed payments due to PHPs in the current quarter for reimbursements to public acute care hospitals that are attributable to newly eligible individuals.

(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 presumptive service cost component calculated under G.S. 108A-147.5 for the current quarter and the administration component calculated under G.S. 108A-147.7 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 for the current quarter.

(2) The nonfederal share for newly eligible individuals of the aggregate amount of the HASP directed payments due to PHPs in the current quarter for reimbursements to UNC Health Care System hospitals that are attributable to newly eligible individuals.

(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 presumptive service cost component calculated under G.S. 108A-147.5 for the current quarter and the administration component calculated under G.S. 108A-147.7 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 for the current quarter.

(2) The nonfederal share for newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine that are attributable to newly eligible individuals.

"**§ 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 IGT share of the reconciliation adjustment component calculated under G.S. 108A-147.11(b) 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.

"**§ 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 positive or negative gross premiums tax offset amount calculated under G.S. 108A-147.12(b).

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

(b) The 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.

"**§ 108A-147.12. Gross premiums tax offset amount.**

(a) For the purposes of this section, the term "annualized offset" means the total paid capitation for all rating groups associated with newly eligible individuals in all capitated contract

plan types for the calendar year that was completed immediately prior to the start of the applicable State fiscal year multiplied by one and nine-tenths percent (1.9%) and then multiplied by sixty percent (60%).

(b) The gross premiums tax offset amount is as follows:

(1) For each quarter of the 2023-2024 and the 2024-2025 State fiscal years, the gross premiums tax offset amount is zero.

(2) For the 2025-2026 State fiscal year, and each fiscal year thereafter, the gross premiums tax offset amount is the following:

a. For the first quarter of the applicable State fiscal year, the gross premiums tax offset amount is a positive or negative number equal to the annualized offset minus the sum of the gross premiums tax offset amounts for the second, third, and fourth quarters of the previous State fiscal year.

b. For the second, third, and fourth quarters of the applicable State fiscal year, the gross premiums tax offset amount is the annualized offset multiplied by one-third.

"**§ 108A-147.13. Use of funds.**

(a) Except as provided in subsection (d) of this section, the proceeds of the health advancement assessments imposed under this Part, and all corresponding matching federal funds, shall only be used to fund the following:

(1) Medicaid actual nonfederal expenditures for newly eligible individuals, including HASP directed payments.

(2) Administrative expenditures for newly eligible individuals.

(3) Administrative expenditures related to the HASP program.

(b) The Department shall use an amount of the proceeds of the health advancement assessments that is equal to the county administration subcomponent of the administration component in G.S. 108A-147.7 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 State administration subcomponent of the administration component in G.S. 108A-147.7 for each quarter of the State fiscal year, and all corresponding matching federal funds.

(d) The Department shall use an amount from the proceeds of the health advancement assessments equal to the State retention component in G.S. 108A-147.8, and all corresponding matching federal funds, for Medicaid program costs."

SECTION 1.6.(c) Article 9 of Chapter 143C of the General Statutes is amended by adding a new section to read:

"**§ 143C-9-10. Health Advancement Receipts Special Fund.**

(a) Creation. – The Health Advancement Receipts Special Fund is established as a nonreverting special fund in the Department of Health and Human Services.

(b) Source of Funds. – Each State fiscal quarter, the Department of Health and Human Services shall deposit in the Health Advancement Receipts Special Fund an amount of funds equal to the total nonfederal receipts for health advancement calculated under G.S. 108A-147.3(b) for that quarter, minus the State retention component under G.S. 108A-147.8 for that quarter, and plus the positive or negative gross premiums tax offset amount calculated under G.S. 108A-147.12(b) for that quarter.

(c) Use of Funds. – The Department of Health and Human Services shall use funds in the Health Advancement Receipts Special Fund only for the purposes described in G.S. 108A-147.13."

SECTION 1.6.(d) Because this act will result in an increase in revenue from the gross premiums tax under G.S. 105-228.5, it is the intent of the General Assembly to appropriate, for each fiscal year, recurring funds to the Department of Health and Human Services, Division of Health Benefits, equaling the total of the gross premiums tax offset amount calculated under G.S. 108A-147.12(b), enacted in Section 1.6(b) of this act, for all four quarters of the State fiscal year.

SECTION 1.6.(e) G.S. 108A-147.7(b), as enacted by Section 1.6(b) of this act, reads as rewritten:

"(b) ~~The State administration subcomponent is three million three hundred thousand dollars ($3,300,000) for each quarter of the 2023-2024 State fiscal year.~~ The State administration subcomponent is four million fifty thousand dollars ($4,050,000) for each quarter of the 2023-2024 State fiscal year. For each subsequent State fiscal year, the State administration subcomponent shall be increased over the prior year's quarterly amount by the Consumer Price Index: All Urban Consumers."

SECTION 1.6.(f) Subsections (b) and (c) of this section become effective January 1, 2024. Subsection (e) of this section becomes effective on the later of the following dates: (i) the first day of the next assessment quarter after the Centers for Medicare and Medicaid Services (CMS) approve the initial 42 C.F.R. § 438.6(c) preprint requesting approval of the healthcare access and stabilization program (HASP) submitted in accordance with G.S. 108A-148.1 or (ii) January 1, 2024. Subsection (e) of this section applies to assessments imposed on or after its effective date.

SECTION 1.6.(g) The Secretary of the Department of Health and Human Services shall notify the Fiscal Research Division and the Revisor of Statutes of the date that CMS approves of the initial 42 C.F.R. § 438.6(c) preprint requesting approval of the HASP program submitted in accordance with G.S. 108A-148.1, as enacted by Section 1.4 of this act. If, by June 30, 2025, the Department of Health and Human Services has not received approval of that preprint, then subsection (e) of this section shall expire on that date.

TECHNICAL AND CONFORMING CHANGES

SECTION 1.7.(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 percentage for each quarter shall equal the aggregate 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."

SECTION 1.7.(b) G.S. 108A-146.3 reads as rewritten:

"**§ 108A-146.3. Private hospital modernized assessment.**

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

(b) The private hospital modernized assessment shall be assessed as a percentage of each private 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 percentage for each quarter shall equal the aggregate modernized assessment collection amount under G.S. 108A-146.5 multiplied by the private hospital historical assessment share and divided by the total hospital costs for all private acute care hospitals holding a license on the first day of the assessment quarter."

SECTION 1.7.(c) G.S. 108A-146.5 reads as rewritten:

"**§ 108A-146.5. Aggregate 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 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.

(b) The total modernized nonfederal receipts is the sum of all of the following:

…

(3a) The modernized HASP component under G.S. 108A-146.10.

…."

SECTION 1.7.(d) G.S. 108A-146.7 reads as rewritten:

"**§ 108A-146.7. Managed care component.**

(a) The managed care component is an amount of money that is a portion of the total paid capitation for all rating groups not associated with newly eligible individuals in all capitated contracted plan types for the previous data collection ~~period and is calculated in accordance with this section.~~ period. The managed care component ~~consists of an inpatient subcomponent and an outpatient subcomponent.~~is calculated by adding the aggregate inpatient subcomponents for all the rating groups calculated under subsection (b) of this section and the aggregate outpatient subcomponents for all the rating groups calculated under subsection (c) of this section.

(b) The inpatient subcomponent is an amount calculated for each rating group not associated with newly eligible individuals by multiplying the paid capitation for the applicable rating group in the previous data collection period by the percentage that is calculated by (i) multiplying the inpatient portion of the statewide capitation rate for the applicable rating group by the inpatient hospital financing percentage, (ii) multiplying that product by the ~~difference of one minus the FMAP,~~ nonfederal share for not newly eligible individuals, and (iii) dividing that product by the statewide capitation rate for the applicable rating group.

(c) The outpatient subcomponent is an amount calculated for each rating group not associated with newly eligible individuals by multiplying the paid capitation for the applicable rating group in the previous data collection period by the percentage that is calculated by (i) multiplying the outpatient portion of the statewide capitation rate for the applicable rating group by the outpatient hospital financing percentage, (ii) multiplying that product by the ~~difference of one minus the FMAP,~~ nonfederal share for not newly eligible individuals, and (iii) dividing that product by the statewide capitation rate for the applicable rating group.

~~(d) The managed care component is calculated by adding together the aggregate inpatient subcomponents for all rating groups and the aggregate outpatient subcomponents for all rating groups.~~"

SECTION 1.7.(e) G.S. 108A-146.9 reads as rewritten:

"**§ 108A-146.9. Fee-for-service component.**

(a) The fee-for-service component is an amount of money that is a portion of all the Medicaid fee-for-service payments made to acute care hospitals during the previous data collection period for claims with a date of service on or after July 1, ~~2021. The fee-for-service component consists of a subcomponent pertaining to claims for which there is no third-party coverage and a subcomponent pertaining to claims for which there is third-party coverage.~~2021, excluding claims attributable to newly eligible individuals. The fee-for-service component is calculated by adding the subcomponent pertaining to claims for which there is no third-party coverage under subsection (b) of this section and the subcomponent pertaining to claims for which there is third-party coverage under subsection (c) of this section.

(b) The subcomponent pertaining to claims for which there is no third-party coverage is the sum of the inpatient amount and the outpatient amount described in this subsection:

(1) The inpatient amount is the product of the total fee-for-service payments for claims not attributable to newly eligible individuals for which there is no third-party coverage made to all acute care hospitals for inpatient hospital services multiplied by the inpatient hospital financing percentage and multiplied by the ~~difference of one minus the FMAP.~~nonfederal share for not newly eligible individuals.

(2) The outpatient amount is the product of the total fee-for-service payments for claims not attributable to newly eligible individuals for which there is no third-party coverage made to all acute care hospitals for outpatient hospital services multiplied by the outpatient hospital financing percentage and multiplied by the ~~difference of one minus the FMAP.~~nonfederal share for not newly eligible individuals.

(c) The subcomponent pertaining to claims for which there is third-party coverage is the product of the total fee-for-service payments for claims not attributable to newly eligible individuals for which there is third-party coverage made for inpatient hospital services and outpatient hospital services to (i) public acute care hospitals, (ii) private acute care hospitals, and (iii) critical access hospitals multiplied by the ~~difference of one minus the FMAP.~~nonfederal share for not newly eligible individuals.

~~(d) The fee-for-service component is calculated by adding together the subcomponent pertaining to claims for which there is no third-party coverage and the subcomponent pertaining to claims for which there is third-party coverage.~~"

SECTION 1.7.(f) Part 2 of Article 7B of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-146.10. Modernized HASP component.**

The modernized HASP component is an amount of money that is calculated each quarter by multiplying the aggregate amount of HASP directed payments due to PHPs in the current quarter for hospital reimbursements that are not attributable to newly eligible individuals by the nonfederal share for not newly eligible individuals."

SECTION 1.7.(g) G.S. 108A-146.11 reads as rewritten:

"**§ 108A-146.11. Graduate medical education component.**

The graduate medical education component is an amount of money that is one-fourth (1/4) of the total amount of payments that will be made by the Department during the current State fiscal year to all public acute care hospitals and private acute care hospitals in accordance with the Medicaid graduate medical education methodology in the Medicaid State Plan multiplied by the ~~difference of one minus the FMAP.~~nonfederal share for not newly eligible individuals."

SECTION 1.7.(h) G.S. 108A-146.13 reads as rewritten:

"**§ 108A-146.13. ~~Intergovernmental transfer~~ Modernized presumptive IGT adjustment component.**

~~(a) The intergovernmental transfer adjustment component is the sum of all of the following subcomponents:~~

~~(1) The historical subcomponent is forty-one million two hundred twenty-seven thousand three hundred twenty-one dollars ($41,227,321) for each quarter of the 2021-2022 State fiscal year. For each subsequent State fiscal year, the historical subcomponent shall be increased over the prior year's quarterly amount by the market basket percentage.~~

~~(2) The postpartum subcomponent applies to the assessments under this Part only during the period of April 1, 2022, through March 31, 2027, and is two million nine hundred sixty-two thousand five hundred dollars ($2,962,500) for each quarter of the 2021-2022 State fiscal year. For each subsequent State fiscal year, the postpartum subcomponent shall be increased over the prior year's quarterly amount by the Medicare Economic Index.~~

~~(3) The home and community-based services subcomponent applies to the assessments under this Part beginning April 1, 2024, and is eight million four hundred thirteen thousand five hundred dollars ($8,413,500) for each quarter of the 2023-2024 State fiscal year. For each subsequent State fiscal year, the home and community-based services subcomponent shall be increased over the prior year's quarterly amount by the Medicare Economic Index.~~

~~(b) If a public acute care hospital closes or becomes a private acute care hospital, then, beginning in the first assessment quarter following the closure or change to a private acute care hospital and for each quarter thereafter, the intergovernmental transfer adjustment component described in subsection (a) of this section, as inflated in accordance with that section, shall be reduced by the amount of the public acute care hospital's intergovernmental transfer to the Department made during its last quarter of operation as a public acute care hospital.~~

(c) The modernized presumptive IGT adjustment component is an amount of money equal to the sum of all of the following subcomponents:

(1) The public hospital IGT subcomponent is the total of the following amounts:

a. Sixteen and forty-three hundredths percent (16.43%) of the amount of money that is equal to the total modernized nonfederal receipts under G.S. 108A-146.5(b) for the current quarter minus the modernized HASP component under G.S. 108A-146.10 for the current quarter.

b. Sixty percent (60%) of the nonfederal share for not newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to public acute care hospitals and that are not attributable to newly eligible individuals.

(2) The UNC Health Care System IGT subcomponent is the total of the following amounts:

a. Four and sixty-two hundredths percent (4.62%) of the difference of the total modernized nonfederal receipts under G.S. 108A-146.5(b) for the current quarter minus the modernized HASP component under G.S. 108A-146.10 for the current quarter.

b. The nonfederal share for not newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to UNC Health Care System hospitals that are not attributable to newly eligible individuals.

(3) The East Carolina University IGT subcomponent is the total of the following amounts:

a. One and four hundredths percent (1.04%) of the difference of the total modernized nonfederal receipts under G.S. 108A-146.5(b) for the current quarter minus the modernized HASP component under G.S. 108A-146.10 for the current quarter.

b. The nonfederal share for not newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine that are not attributable to newly eligible individuals."

SECTION 1.7.(i) Part 2 of Article 7B of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 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 modernized presumptive IGT adjustment component under G.S. 108A-146.13 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."

SECTION 1.7.(j) G.S. 108A-146.15 reads as rewritten:

"**§ 108A-146.15. Use of funds.**

The proceeds of the assessments imposed under this Part, and all corresponding matching federal funds, must be used to make the State's annual Medicaid payment to the ~~State, to fund payments~~ State and to fund all of the following:

(1) Payments to hospitals made directly by the ~~Department, to fund a~~ Department.

(2) A portion of capitation payments to prepaid health plans attributable to hospital ~~care, and to fund graduate~~ care.

(3) HASP directed payments attributable to hospital reimbursements for not newly eligible individuals.

(4) Graduate medical education payments."

SECTION 1.7.(k) G.S. 108A-146.12 reads as rewritten:

"**§ 108A-146.12. Postpartum coverage component.**

(a) The postpartum coverage component is twelve million five hundred thousand dollars ($12,500,000) for each quarter of the 2021-2022 State fiscal year.

(b) For each quarter of the 2022-2023 State fiscal year, the postpartum coverage component is eleven million four thousand four hundred twenty-four dollars ($11,004,424).

(c) For the first and second quarters of the 2023-2024 State fiscal year, the postpartum coverage component is eleven million four thousand four hundred twenty-four dollars ($11,004,424) increased by the Medicare Economic Index.

(d) For the third and fourth quarters of the 2023-2024 State fiscal year, the postpartum coverage component is four million five hundred thousand dollars ($4,500,000).

(e) For each quarter of the 2024-2025 State fiscal year, the postpartum coverage component is four million five hundred thousand dollars ($4,500,000) increased by the Medicare Economic Index.

(f) Reserved for future codification purposes.

(g) Reserved for future codification purposes.

(h) Reserved for future codification purposes.

(i) For each ~~subsequent~~ State fiscal ~~year,~~ year after the 2025-2026 fiscal year, the postpartum coverage component shall be increased over the prior year's quarterly amount by the Medicare Economic Index."

SECTION 1.7.(*l*) Section 2.1 of S.L. 2021-61 reads as rewritten:

"**SECTION 2.1.** Notwithstanding the definition of ~~federal medical assistance percentage (FMAP)~~ FMAP for not newly eligible individuals in G.S. 108A-145.3, for any quarter in which the State receives the temporary increase of Medicaid FMAP allowed under (i) section 6008 of the Families First Coronavirus Response Act, P.L. 116-127, or (ii) section 9814 of the American Rescue Plan Act of 2021, P.L. 117-2, the FMAP for purposes of Article 7B of Chapter 108A of the General Statutes shall be the federal share of North Carolina Medicaid service costs as calculated by the federal Department of Health and Human Services in accordance with section 1905(b) of the Social Security Act in effect at the start of the applicable assessment quarter, plus the applicable temporary increase, expressed as a decimal."

SECTION 1.7.(m) Section 9D.13A(e) of S.L. 2021-180 is repealed.

SECTION 1.7.(n) Section 9D.14 of S.L. 2021-180 is repealed.

SECTION 1.7.(o) G.S. 108D-65(6)a. reads as rewritten:

"a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the ~~Actuary for nonexpansion states.~~Actuary."

SECTION 1.7.(p) Subsections (k) through (*l*) of this section become effective January 1, 2024, and apply to assessments imposed on or after that date. Subsections (m) through (o) of this section become effective January 1, 2024. The remainder of this section is effective on the first day of the next assessment quarter after this act becomes effective and applies to assessments imposed on or after that date.

ADDITIONAL FUNDS FOR COUNTIES

SECTION 1.8.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health Benefits, the sum of fifty million dollars ($50,000,000) in nonrecurring funds for the 2023-2024 fiscal year to be distributed to all counties to be used for the administrative costs of Medicaid eligibility determinations and for inmate medical costs. The funds shall be distributed to the counties on a per capita basis, except that each county shall receive at least one hundred thousand dollars ($100,000).

SECTION 1.8.(b) Subsection (a) of this section is effective the later of July 1, 2023, or the date the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law.

SECTION 1.8.(c) Effective when this act becomes law, the provisions of G.S. 143C-5-2 do not apply to this act.

PART II. CREATING SEAMLESS WORKFORCE DEVELOPMENT OPPORTUNITIES

SECTION 2.1.(a) No later than December 1, 2024, the Secretary of the Department of Commerce (Secretary) shall develop a plan to create a seamless, statewide, comprehensive workforce development program, bringing together new opportunities with the current workforce development opportunities within the Department of Commerce (Commerce), the Department of Labor (Labor), and other State agencies. The plan to create a seamless, statewide, comprehensive workforce development program shall be developed in collaboration with the stakeholders outlined in subsection (b) of this section. The Secretary may contract with third-party entities in the development and implementation of the plan. As part of the plan, the Secretary shall strive to ensure that all workforce development opportunities are available to participants statewide by coordinating efforts and resources across State agencies.

The plan developed under this section shall include all of the following components:

(1) Identification of currently existing workforce development programs for unemployed individuals or low-wage workers in this State and any gaps or opportunities for improvement of those existing programs.

(2) Identification of the specific labor force needs within the State, specifically including healthcare workforce needs.

(3) Identification of the specific needs of current and potential future workforce development participants in order to achieve the goal of reducing the number of people that are utilizing social service programs, including the North Carolina Medicaid program.

(4) All of the following specific services shall be included in the plan:
   a. Job training assistance.
   b. Career paths and job readiness.
   c. Job placement.
   d. Resources for job seekers.
   e. Recruiting services.
   f. Healthcare workforce support.

(5) Measures by which to determine the success of the workforce development programs, such as increases in participant earning capacity, greater economic stability of participants, and self-sufficiency of participants.

SECTION 2.1.(b) As part of the development of the plan required under subsection (a) of this section, the Secretary shall collaborate with the following entities:

(1) The Department of Labor.
(2) NCWorks.
(3) The North Carolina Community College System.
(4) The North Carolina Area Health Education Centers (AHEC).
(5) The Department of Public Instruction.
(6) The University of North Carolina.
(7) The Department of Health and Human Services (DHHS).
(8) Hospitals and healthcare providers licensed in the State.
(9) Prepaid health plans, as defined under G.S. 108D-1.
(10) The North Carolina nonprofit corporation with which the Department of Commerce contracts pursuant to G.S. 143B-431.01(b).
(11) The North Carolina Chamber of Commerce.
(12) Any North Carolina community organization with relevant expertise.
(13) Local workforce development boards.

SECTION 2.1.(c) No later than December 1, 2024, the Secretary of Commerce shall report to the Joint Legislative Oversight Committee on General Government, the Joint Legislative Oversight Committee on Health and Human Services, and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice regarding the plan required under subsection (a) of this section. The report shall include, at a minimum, all of the following:

(1) The comprehensive plan developed in accordance with this section, including the anticipated date of implementation.
(2) Identification of the entity within the Department of Commerce that will be responsible for implementation of the plan.
(3) The workforce needs of North Carolina employers by industry, skill, required education level, and geography.
(4) Existing workforce development gaps and opportunities for improvement.
(5) Workforce training infrastructure and needs.
(6) Any cost to the State to implement the plan and to continue successful operation of the plan into the future.
(7) Any recommended legislation.

SECTION 2.2.(a) In collaboration with Commerce, DHHS shall develop a method by which to assist individuals enrolled in the North Carolina Medicaid program and other relevant social service programs with accessing appropriate workforce development services. DHHS shall develop a plan for assessing the current employment status and any barriers to employment of newly enrolled Medicaid beneficiaries, including the enrollees that will be newly eligible for Medicaid benefits under Section 1.1 of this act, as well as newly enrolled participants in other relevant social service programs. DHHS and Commerce shall work together to determine the best method by which Medicaid beneficiaries and beneficiaries of other relevant social service programs will be provided an initial assessment and consultation with a workforce development case manager, or other similar professional, to ensure that interested individuals are able to fully participate in the workforce development programs offered in this State. DHHS may contract with third-party entities or prepaid health plans, as defined under G.S. 108D-1, to assist in providing these services and may consider the use of incentives to prepaid health plans with regard to these services.

SECTION 2.2.(b) No later than December 1, 2024, DHHS shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and to the Joint Legislative Oversight Committee on Health and Human Services on the method determined to be best to provide Medicaid beneficiaries and beneficiaries of other relevant social service programs an initial assessment and consultation with a workforce development case manager, or other similar

professional, as required by subsection (a) of this section. The report shall include a time line for implementation of that method and the annual cost to DHHS for both the initial implementation and ongoing costs.

SECTION 2.2.(c) Beginning February 1, 2025, and for five years thereafter, DHHS, in collaboration with Commerce, shall report no later than February 1 of each year to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and to the Joint Legislative Oversight Committee on Health and Human Services all of the following information:

(1) The total number of Medicaid beneficiaries and beneficiaries of other relevant social service programs who have participated in workforce development, including the number of individuals who completed an assessment by a workforce development case manager or similar professional.

(2) A breakdown of the types of workforce development services or programs that participants utilized, including specific information about the activities participated in by beneficiaries of Medicaid and other relevant social service programs.

(3) General demographic information for the beneficiaries of Medicaid and other relevant social service programs who participated in workforce development programs.

(4) The average length of time individuals who participated in workforce development programs and were eligible for Medicaid benefits or benefits under other beneficiaries of Medicaid and other relevant social service programs remained eligible for those benefits.

(5) The number of individuals who were employed or reemployed in a position providing higher wages as a result of participation in a workforce development program.

(6) The number of individuals who were no longer qualified for Medicaid or any other relevant social service program due to obtaining gainful employment or higher wages as a result of participation in any workforce development program.

SECTION 2.3.(a) The General Assembly finds that awareness of, and assistance with, enrollment in health benefit coverage on the federal Health Insurance Marketplace will alleviate the false perception that the loss of Medicaid coverage equals an immediate loss of access to healthcare. In order to counteract any disincentive to obtaining employment or increasing income that this false perception may bring and in order to facilitate a smoother transition of health benefit coverage from Medicaid to private insurance, the Department of Health and Human Services, Division of Health Benefits (DHB), shall work with the NC Navigators Consortium to develop a mechanism by which a Medicaid recipient who is transitioning from qualifying for the Medicaid program to qualifying for premium or cost-sharing assistance for health insurance obtained on the Health Insurance Marketplace, or who could reasonably be determined to be eligible for that premium or cost-sharing assistance in the near future, will be assisted with that transition by a qualified Navigator or similar professional. At a minimum, and no later than January 1, 2024, DHB shall provide all Medicaid applicants written notification about the Health Insurance Marketplace that includes contact information for the NC Navigators Consortium. Written notification about the Health Insurance Marketplace that includes contact information for the NC Navigators Consortium shall also be provided to all Medicaid recipients except those recipients qualifying under subdivision (14), (17), (18), (19), or (20) of G.S. 108A-54.3A upon each redetermination and upon termination from the Medicaid program.

SECTION 2.3.(b) No later than March 1, 2024, DHB shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice all of the following information:

(1) Details of the mechanism, developed in accordance with subsection (a) of this section, to assist a Medicaid recipient who is transitioning from qualifying for the Medicaid program to qualifying for premium or cost-sharing assistance for health insurance obtained on the Health Insurance Marketplace, or who could reasonably be determined to be eligible for that premium or cost-sharing assistance in the near future, with that transition by a qualified Navigator or similar professional.

(2) Specific details on the written notification being provided to all Medicaid applicants and certain Medicaid recipients, as required by subsection (a) of this section.

SECTION 2.4. If there is any indication that work requirements as a condition of participation in the Medicaid program may be authorized by the Centers for Medicare and Medicaid Services (CMS), then the Department of Health and Human Services, Division of Health Benefits (DHB), shall enter into negotiations with CMS to develop a plan for those work requirements and to obtain approval of that plan. Within 30 days of entering into negotiations with CMS pursuant to this section, DHB shall notify, in writing, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice (JLOC) and the Fiscal Research Division (FRD) of these negotiations. Within 30 days of approval by CMS of a plan for work requirements as a condition of participation in the Medicaid program, DHB shall submit a report to JLOC and FRD containing the full details of the approved work requirements, including the approved date of implementation of the requirements.

SECTION 2.5.(a) Definitions. – The following definitions apply in this section:

(1) Authority. – The State Education Assistance Authority.

(2) Eligible postsecondary institution. – Any of the following:

a. A community college, as defined in G.S. 115D-2.

b. A postsecondary constituent institution of The University of North Carolina, as defined in G.S. 116-2(4).

c. An eligible private postsecondary institution, as defined in G.S. 116-280(3).

(3) Eligible student. – Either of the following types of students enrolled in an eligible postsecondary institution in the 2024-2025 academic year as a first-year student in a program of study approved by the Authority for students to receive funds under the Forgivable Education Loans for Service Program, pursuant to G.S. 116-209.45, related to the following degrees:

a. A student enrolled in a medical school for purposes of becoming a licensed physician.

b. A student enrolled in an associate, bachelor, masters, or doctoral degree program in nursing for purposes of becoming a licensed nurse.

(4) Loan. – A forgivable loan made under the Pilot Program.

(5) Pilot Program. – The Doctors and Nurses in Rural Areas Forgivable Loan Pilot Program.

(6) Rural area. – A county located in North Carolina that is designated by the NC Rural Center as a rural county.

SECTION 2.5.(b) Program; Purpose. – There is established the Doctors and Nurses in Rural Areas Forgivable Loan Pilot Program to be administered by the Authority. The purpose of the Pilot Program is, to the extent funds are provided pursuant to this section, to provide forgivable loans to eligible students who agree to practice medicine or nursing on a full-time basis in a rural area.

SECTION 2.5.(c) Eligibility. – The Authority shall establish the criteria for initial and continuing eligibility to participate in the Pilot Program, including at least the following:

(1) All loan recipients shall be residents of North Carolina and shall attend an eligible postsecondary institution.

(2) Standards necessary to ensure only qualified persons receive a loan under the Pilot Program, including priority for applicants from rural areas. These standards may also include minimum grade point average and satisfactory academic progress.

(3) To the extent funds provided pursuant to this section are insufficient to award forgivable loans to all interested, eligible students, the Authority may establish a lottery process for selection of loan recipients from among qualified applicants within criteria established by this section.

SECTION 2.5.(d) Loan Terms and Conditions. – To the extent funds are made available to provide loans pursuant to the Pilot Program, the following terms and conditions shall apply to each loan made pursuant to this section:

(1) Promissory note. – All loans shall be evidenced by promissory notes made payable to the Authority.

(2) Interest. – All promissory notes shall bear an interest rate established by the Authority that does not exceed ten percent (10%) and is in relation to the current interest rate for non-need-based federal loans made pursuant to Title IV of the Higher Education Act of 1965, as amended. Interest shall accrue from the date of disbursement of the loan funds.

(3) Loan amount. – Loans shall be awarded to eligible students each academic year, per eligible student, for up to four academic years, based on the degree the student is pursuing in the amounts provided in the below table.

Degree	Award Amount Per Year
Doctor of Medicine	$28,000
Doctor in Nursing	$28,000
Masters in Nursing	$20,000
Bachelor in Nursing	$14,000
Associate in Nursing	$6,000

(4) Forgiveness and repayment. – The Authority shall forgive loans based on the amount received by the eligible student per year pursuant to the table listed in subdivision (3) of this subsection for each year that the recipient works as a licensed physician or nurse practicing on a full-time basis in a rural area, up to the total amount initially awarded to the recipient pursuant to subdivision (3) of this subsection. The Authority shall establish any other necessary criteria for loan forgiveness for qualifying employment. The criteria may provide for accelerated repayment and less than full-time employment options. The Authority shall collect cash repayments when service repayment is not completed. The Authority shall establish the terms for cash repayment, including a minimum monthly repayment amount and maximum period of time to complete repayment.

(5) Death and disability. – The Authority may forgive all or part of a loan if it determines that it is impossible for the recipient to repay the loan in cash or service because of the death or disability of the recipient.

(6) Hardship. – The Authority may grant a forbearance, a deferment, or both in hardship circumstances when a good-faith effort has been made to repay the loan in a timely manner.

(7) Other. – The Authority may establish other terms and conditions that are necessary or convenient to effectuate the Pilot Program.

SECTION 2.5.(e) Rulemaking Authority. – The Authority may adopt rules necessary to implement, administer, market, and enforce the provisions of this section.

SECTION 2.5.(f) Report to the General Assembly. – The Authority shall report no later than December 1, 2024, and annually thereafter while loans are held or forgiven by the Authority, to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services regarding the Pilot Program and loans awarded pursuant to the Pilot Program, including at least the following information:

(1) Forgivable loans awarded by the Authority, including the following:
   a. Demographic information regarding loan recipients.
   b. Number of loan recipients by degree and eligible postsecondary institution.

(2) Placement and repayment rates, including the following:
   a. Number of loan recipients who have been employed on a full-time basis in a rural area within two years of graduation.
   b. Number of loan recipients who have elected cash repayment in lieu of service repayment and their years of service, if any, prior to beginning cash repayment.

(3) Recommendations to expand the Pilot Program and increase the number of licensed physicians and nurses practicing in rural areas.

SECTION 2.5.(g) There is appropriated from the General Fund to the Board of Governors of The University of North Carolina for the 2023-2024 fiscal year the sum of fourteen million four hundred thousand dollars ($14,400,000) in nonrecurring funds to be allocated to the State Education Assistance Authority to provide forgivable loans to an estimated 200 eligible students in accordance with the Doctors and Nurses in Rural Areas Forgivable Loan Pilot Program established pursuant to subsection (a) of this section. Except as provided in subdivision (4) of subsection (d) of this section, these funds shall not revert to the General Fund at the end of the 2023-2024 fiscal year but shall remain available until expended. The Authority may use up to two hundred thousand dollars ($200,000) of these funds for administrative costs related to the Pilot Program.

SECTION 2.5.(h) Subsections (a) through (g) of this section are effective the later of July 1, 2023, or the date the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law.

SECTION 2.5.(i) Effective when this act becomes law, the provisions of G.S. 143C-5-2 do not apply to this act.

PART III. EFFECTIVE DATE

SECTION 3. Except as otherwise provided, this act is effective on the date that the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law. If, by December 31, 2023, no Current Operations Appropriations Act for the 2023-2024 fiscal year has become law, then this act shall expire.