GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2023



# HOUSE BILL 76
**Second Edition Engrossed 2/16/23**
**Senate Health Care Committee Substitute Adopted 3/8/23**

Short Title: Access to Healthcare Options. (Public)

Sponsors:

Referred to:

February 9, 2023

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

## PART I. MEDICAID

### NC HEALTH WORKS

**SECTION 1.1.(a)** Section 3 of S.L. 2013-5 is repealed.

**SECTION 1.1.(b)** 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 who are in compliance with any work requirements established in the State Plan and in rule. 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)** Subsection (b) of this section is effective on the later of the following dates:

(1) The date approved by the Centers for Medicare and Medicaid Services (CMS) for Medicaid coverage to begin in North Carolina for individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

(2) The date the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law.

**SECTION 1.1.(d)** The Secretary of the Department of Health and Human Services shall notify the Fiscal Research Division and the Revisor of Statutes of the date approved by CMS for Medicaid coverage to begin in North Carolina for individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

**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, 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, 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, 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 is effective on the later of the following dates:

(1) The date approved by the Centers for Medicare and Medicaid Services (CMS) for Medicaid coverage to begin in North Carolina for individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

(2) The date the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law.

**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.

**SECTION 1.3.(c)** This section is effective on the date the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law.

**HEALTHCARE ACCESS AND STABILIZATION PROGRAM**

**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, 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 with implementation of 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 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 1.5.(d)** This section is effective on the date that the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law. If, by September 30, 2023, no Current Operations Appropriations Act for the 2023-2024 fiscal year has become law, then this section shall expire on that date.

**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 every State fiscal quarter prior to the fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, the presumptive service cost component is zero.

(b) For the State fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, the presumptive service cost component is the product of forty-eight million seven hundred fifty thousand dollars ($48,750,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(24) is effective during any part of the month.

(c) For the first State fiscal quarter after the State fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, the presumptive service cost component is one hundred forty-six million two hundred fifty thousand dollars ($146,250,000).

(d) For the second State fiscal quarter after the State fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, and for each State fiscal quarter thereafter, 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) For each quarter of the 2022-2023 State fiscal year and the 2023-2024 State fiscal year, the State administration subcomponent is the product of one million one hundred thousand dollars ($1,100,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(24) is effective during any part of the month. For each quarter of the 2024-2025 State fiscal year, the State administration subcomponent is three million three hundred thousand dollars ($3,300,000) increased by the Consumer Price Index: All Urban Consumers. 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) For each quarter of the 2022-2023 State fiscal year and the 2023-2024 State fiscal year, the county administration subcomponent is the product of one million six hundred sixty-seven thousand dollars ($1,667,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(24) is effective during any part of the month. The county administration subcomponent is seven million four hundred thousand dollars ($7,400,000) for each quarter of the 2024-2025 State fiscal year and seven million eight hundred thousand dollars ($7,800,000) for each quarter of the 2025-2026 State fiscal year. For each State fiscal year after the 2025-2026 State fiscal year, the 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.**

(a) For every State fiscal quarter prior to the fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, the State retention component is zero.

(b) For the State fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, and each State fiscal quarter thereafter, 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 2022-2023 State fiscal year and the 2023-2024 State fiscal year, the gross premiums tax offset amount is zero.
(2) For the 2024-2025 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) For each quarter of ~~the 2022-2023 State fiscal year and~~ the 2023-2024 State fiscal year, the State administration subcomponent is the product of ~~one million one hundred thousand dollars ($1,100,000)~~ one million three hundred fifty thousand dollars ($1,350,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(24) is effective during any part of the month. For each quarter of the 2024-2025 State fiscal year, the State administration subcomponent is ~~three million three hundred thousand dollars ($3,300,000)~~ four million fifty thousand dollars ($4,050,000) increased by the Consumer Price Index: All Urban Consumers. 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 on the first day of the next assessment quarter after this act becomes law. 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) the first day of the next assessment quarter after this act becomes law. 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.

**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,~~ year prior to the State fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, the postpartum coverage component is eleven million four thousand four hundred twenty-four dollars ($11,004,424). For any quarter of the 2022-2023 State fiscal year in which G.S. 108A-54.3A(24) becomes or is effective, the postpartum coverage component is four million five hundred thousand dollars ($4,500,000).

(c) For each quarter of the 2023-2024 State fiscal year prior to the State fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, the postpartum coverage component is eleven million four thousand four hundred twenty-four dollars ($11,004,424) increased by the Medicare Economic Index. For any quarter of the 2023-2024 State fiscal year in which G.S. 108A-54.3A(24) becomes or is effective, the postpartum coverage component is four million five hundred thousand dollars ($4,500,000).

(d) 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.

(e) Reserved for future codification purposes.

(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)** G.S. 105-523(b)(2) reads as rewritten:

"(2) Hold harmless threshold. – The amount of a county's Medicaid service costs and Medicare Part D clawback payments assumed by the State under G.S. 108A-54 for the fiscal year. A county's Medicaid service costs for fiscal years 2008-2009, 2009-2010, and 2010-2011 are determined without regard to the changes made to the Federal Medical Assistance Percentage by section 5001 of the American Recovery and Reinvestment Act of 2009. A county's Medicaid service costs do not include any costs for newly eligible individuals as defined in G.S. 108A-145.3."

**SECTION 1.7.(q)** Subsection (k) of this section becomes effective on the first day of the next assessment quarter after the date the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law and applies to assessments imposed on or after that date. Subsections (*l*) through (p) of this section become effective on the date the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law. The remainder of this section is effective on the first day of the next assessment quarter after this section becomes law and applies to assessments imposed on or after that date.

**DECREASE MEDICAID ENROLLMENT BURDEN ON COUNTY DEPARTMENTS OF SOCIAL SERVICES**

**SECTION 1.8.(a)** Notwithstanding G.S. 108A-54(d) and in accordance with G.S. 143B-24(b), the Department of Health and Human Services (DHHS) is authorized, on a temporary basis to conclude no later than 12 months after the date approved by the Centers for Medicare and Medicaid Services (CMS) for Medicaid coverage to begin in North Carolina for individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to utilize the

federally facilitated marketplace (Marketplace), also known as the federal health benefit exchange, to make Medicaid eligibility determinations. In accordance with G.S. 108A-54(b), these eligibility determinations shall be in compliance with all eligibility categories, resource limits, and income thresholds set by the General Assembly.

**SECTION 1.8.(a1)** Notwithstanding G.S. 108A-54(d) and in accordance with G.S. 143B-24(b), DHHS is authorized to make any necessary request to, or enter into any agreement with, the Marketplace to facilitate the ability of the Marketplace to make Medicaid eligibility determinations as soon as the use of the Marketplace for this purpose is authorized by the General Assembly, as provided for under subsection (a) of this section.

**SECTION 1.8.(b)** G.S. 108A-25(b) reads as rewritten:

"(b) The program of medical assistance is established as a program of public assistance and shall be administered by the Department of Health and Human Services in accordance with G.S. 108A-54. Medicaid eligibility administration may be delegated to the county departments of social services under rules adopted by the Department of Health and Human Services. Provided the Secretary has been given appropriate authorization by the General Assembly under G.S. 143B-24(b), the county departments of social services shall, upon direction of the Secretary, accept Medicaid eligibility determinations made by the federally facilitated marketplace, also known as the federal health benefit exchange."

**SECTION 1.8.(c)** G.S. 108A-25.1A is amended by adding a new subsection to read:

"(b1) Notwithstanding subsection (a) of this section, a county department of social services shall not be financially responsible for the erroneous issuance of Medicaid benefits and Medicaid claims payments resulting from a failure or error attributable solely to the federally facilitated marketplace, also known as the federal health benefit exchange."

**SECTION 1.8.(d)** G.S. 108A-70.36 reads as rewritten:

"Part 10. Medicaid Eligibility Decision Processing Timeliness.

"**§ 108A-70.36. Applicability.**

(a) If a federally recognized Native American tribe within the State has assumed responsibility for the Medicaid program pursuant to G.S. 108A-25(e), then this Part applies to the tribe in the same manner as it applies to county departments of social services.

(b) This Part shall not apply to any eligibility determinations made by the federally facilitated marketplace, also known as the federal health benefit exchange, so long as use of the federally facilitated marketplace for Medicaid eligibility determinations has been authorized by the General Assembly, in accordance with G.S. 143B-24(b)."

**SECTION 1.8.(e)** G.S. 108A-55.3(b) reads as rewritten:

"(b) An applicant may meet the requirements of subsection (a) of this section by providing at least ~~two~~ one of the following documents:

…."

**SECTION 1.8.(f)** G.S. 108A-55.3(c) reads as rewritten:

"(c) For ~~applicants, including those who are homeless or migrant laborers,~~ applicants who declare under penalty of perjury that they do not have ~~two~~ any of the verifying documents in subsection (b) of this section, any other evidence that verifies residence may be considered. However, except for applicants of emergency Medicaid, a declaration, affidavit, or other statement from the applicant or another person that the applicant meets the requirements of G.S. 108A-24(6) is insufficient in the absence of other credible evidence. For applicants of emergency Medicaid, a declaration, affidavit, or other statement from the applicant's employer, clergy, or other person with personal knowledge of the applicant's intent to live in North Carolina permanently or for an indefinite period of time or that the applicant is residing in North Carolina to seek employment or with a job commitment satisfies the requirements of this subsection."

**SECTION 1.8.(g)** Subsection (a) of this section expires 12 months after the date approved by the Centers for Medicare and Medicaid Services (CMS) for Medicaid coverage to

begin in North Carolina for individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

**SECTION 1.8.(h)** Subsection (a) and subsections (b) through (g) of this section are effective on the date the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law.

## PART IA. NC HEALTH WORKS NOT EFFECTIVE UNLESS THE 2023-2024 BUDGET HAS BEEN ENACTED IN THE 2023-2024 FISCAL YEAR

**SECTION 1A.1.** If, by June 30, 2024, no Current Operations Appropriations Act for the 2023-2024 fiscal year has become law, then Part I of this act shall expire on that date, except for the following sections:

(1) Section 1.4.
(2) Subsections (a), (f), and (g) of Section 1.6.
(3) Subsections (a) through (j) and (q) of Section 1.7.

## PART II. CREATING SEAMLESS WORKFORCE DEVELOPMENT OPPORTUNITIES

### COMPREHENSIVE WORKFORCE DEVELOPMENT PROGRAM

**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.
(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 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, the Department of Health and Human Services (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 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 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.

**NOTICE TO MEDICAID BENEFICIARIES OF HEALTH INSURANCE MARKETPLACE**

**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 or electronic notification about the Health Insurance Marketplace that includes contact information for the NC Navigators Consortium. Written or electronic 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 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.

**PURSUIT OF MEDICAID WORK REQUIREMENTS**

**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 (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.** Sections 2.1 through 2.4 of this act are effective the date the Current Operations Appropriations Act for the 2023-2024 fiscal year becomes law. If, by June 30, 2024, no Current Operations Appropriations Act for the 2023-2024 fiscal year has become law, then those sections shall expire on that date.

**PART III. CERTIFICATE OF NEED REFORMS**

**REFORMS EFFECTIVE IMMEDIATELY**

**SECTION 3.1.(a)** G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

The following definitions apply in this Article:

…

(7a) Diagnostic center. – "Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds ~~one million five hundred thousand dollars ($1,500,000).~~ three million dollars ($3,000,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than ~~one million five hundred thousand dollars ($1,500,000),~~ three million dollars ($3,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2022, and on

September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

…

(9b) Health service facility. – A hospital; long-term care hospital; ~~psychiatric facility;~~ rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; ~~chemical dependency treatment facility;~~ diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

(9c) Health service facility bed. – A bed licensed for use in a health service facility in the categories of (i) acute care beds; ~~(ii) psychiatric beds;~~ (iii) rehabilitation beds; (iv) nursing home beds; (v) intermediate care beds for individuals with intellectual disabilities; ~~(vi) chemical dependency treatment beds;~~ (vii) hospice inpatient facility beds; (viii) hospice residential care facility beds; (ix) adult care home beds; and (x) long-term care hospital beds.

…

(22a) Replacement equipment. – Equipment that costs less than ~~two million dollars ($2,000,000)~~ three million dollars ($3,000,000) and is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. In determining whether the replacement equipment costs less than ~~two million dollars ($2,000,000),~~ three million dollars ($3,000,000) the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2023, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

…."

**SECTION 3.1.(b)** G.S. 131E-184 reads as rewritten:

"**§ 131E-184. Exemptions from review.**

(a) Except as provided in subsection (b) of this section, the Department shall exempt from certificate of need review a new institutional health service if it receives prior written notice from the entity proposing the new institutional health service, which notice includes an explanation of why the new institutional health service is required, for any of the following:

…

(10) To allow a licensed home care agency, as defined in G.S. 131E-136, to provide Early and Periodic Screening, Diagnosis, and Treatment services to children up to 21 years of age, in compliance with federal Medicaid requirements under 42 U.S.C. § 1396d. This exemption applies to all home care agencies licensed under Article 6 of this Chapter, whether or not they are Medicare-certified.

…

~~(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric beds provided all of the following are true:~~

~~(1) The hospital proposing the conversion has executed a contract with the Department's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, one or more of the area mental health, developmental disabilities, and substance abuse authorities, or a combination thereof to provide psychiatric beds to patients referred by the contracting agency or agencies.~~

~~(2) The total number of beds to be converted shall not be more than twice the number of beds for which the contract pursuant to subdivision (1) of this subsection shall provide.~~

~~(d) In accordance with, and subject to the limitations of G.S. 148-19.1, the Department shall exempt from certificate of need review the construction and operation of a new chemical dependency or substance abuse facility for the purpose of providing inpatient chemical dependency or substance abuse services solely to inmates of the Department of Adult Correction. If an inpatient chemical dependency or substance abuse facility provides services both to inmates of the Department of Adult Correction and to members of the general public, only the portion of the facility that serves inmates shall be exempt from certificate of need review.~~

(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the ~~two million dollar ($2,000,000)~~ monetary threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The proposed capital expenditure would meet all of the following requirements:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding any of the following existing facilities:

1. Nursing home facility.
2. Adult care home facility.
3. Intermediate care facility for individuals with intellectual disabilities.

b. Not result in a change in bed capacity, as defined in G.S. 131E-176(5), or the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation that demonstrates that the proposed capital expenditure would be used for one or more of the following purposes:

a. Conversion of semiprivate resident rooms to private rooms.
b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.
c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents.

(f) The Department shall exempt from certificate of need review the purchase of any replacement equipment that exceeds the ~~two million dollar ($2,000,000)~~ monetary threshold set forth in G.S. 131E-176(22a) if all of the following conditions are met:

(1) The equipment being replaced is located on the main campus.

(2) The Department has previously issued a certificate of need for the equipment being replaced. This subdivision does not apply if a certificate of need was not required at the time the equipment being replaced was initially purchased by the licensed health service facility.

(3) The licensed health service facility proposing to purchase the replacement equipment shall provide prior written notice to the Department, along with

supporting documentation to demonstrate that it meets the exemption criteria of this subsection.

(g) The Department shall exempt from certificate of need review any capital expenditure that exceeds the ~~two million dollar ($2,000,000)~~ monetary threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The sole purpose of the capital expenditure is to renovate, replace on the same site, or expand the entirety or a portion of an existing health service facility that is located on the main campus.

(2) The capital expenditure does not result in (i) a change in bed capacity as defined in G.S. 131E-176(5) or (ii) the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(3) The licensed health service facility proposing to incur the capital expenditure shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection.

…."

**SECTION 3.1.(c)** G.S. 148-19.1 reads as rewritten:

"**§ 148-19.1. Exemption from ~~licensure and certificate of need.~~licensure.**

~~(a)~~ Inpatient chemical dependency or substance abuse facilities that provide services exclusively to inmates of the Department of Adult Correction or offenders under the supervision of the Division of Community Supervision and Reentry of the Department of Adult Correction shall be exempt from licensure by the Department of Health and Human Services under Chapter 122C of the General Statutes. If an inpatient chemical dependency or substance abuse facility provides services both to inmates or offenders under supervision and to members of the general public, the portion of the facility that serves inmates or offenders under supervision shall be exempt from licensure.

~~(b) Any person who contracts to provide inpatient chemical dependency or substance abuse services to inmates of the Department of Adult Correction or to offenders under the supervision of the Division of Community Supervision and Reentry of the Department of Adult Correction may construct and operate a new chemical dependency or substance abuse facility for that purpose without first obtaining a certificate of need from the Department of Health and Human Services pursuant to Article 9 of Chapter 131E of the General Statutes. However, a new facility or addition developed for that purpose without a certificate of need shall not be licensed pursuant to Chapter 122C of the General Statutes and shall not admit anyone other than inmates unless the owner or operator first obtains a certificate of need.~~"

**SECTION 3.1.(d)** No person is required to obtain a certificate of need under Article 9 of Chapter 131E of the General Statutes prior to initiating the following:

(1) The conversion of health service facility beds that obtained certificate of need approval prior to the effective date of this section into chemical dependency treatment facility beds or psychiatric beds.

(2) An increase in the number of health service facility beds that obtained certificate of need approval prior to the effective date of this section as chemical dependency treatment facility beds or psychiatric beds.

**SECTION 3.1.(e)** This section is effective when it becomes law and applies to activities occurring on or after that date.

**REFORMS EFFECTIVE TWO YEARS AFTER ISSUANCE OF THE FIRST HASP DIRECTED PAYMENT**

**SECTION 3.2.(a)** G.S. 131E-176, as amended by Section 3.1 of this act, reads as rewritten:

"**§ 131E-176. Definitions.**

The following definitions apply in this Article:

…

(9b) Health service facility. – A hospital; long-term care hospital; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility. The term "health service facility" does not include a qualified urban ambulatory surgical facility.

…

(16) New institutional health services. – Any of the following:

…

b. Except with respect to qualified urban ambulatory surgical facilities and except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding four million dollars ($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds four million dollars ($4,000,000). Beginning September 30, 2022, and on September 30 each year thereafter, the amount in this sub-subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

…

(21a) Qualified urban ambulatory surgical facility. – An ambulatory surgical facility that meets all of the following criteria:

a. Is licensed by the Department to operate as an ambulatory surgical facility.

b. Has a single specialty or multispecialty ambulatory surgical program.

c. Is located in a county with a population greater than 125,000 according to the 2020 federal decennial census or any subsequent federal decennial census.

…

(24f) Specialty ambulatory surgical program. – A formal program for providing on a same-day basis surgical procedures ~~for only the specialty areas identified on the ambulatory surgical facility's 1993 Application for Licensure as an Ambulatory Surgical Center~~ of the same surgical specialty and authorized by its certificate of ~~need.~~need, if a certificate of need is required.

…."

**SECTION 3.2.(b)** G.S. 131E-146 is amended by adding a new subdivision to read:

"(3) "Qualified urban ambulatory surgical facility" means an ambulatory surgical facility that meets the definition of G.S. 131E-176(21a)."

**SECTION 3.2.(c)** Part 4 of Article 6 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-147.5. Charity care requirement for qualified urban ambulatory surgical facilities; annual report.**

(a) The percentage of each qualified urban ambulatory surgical facility's total earned revenue that is attributed to self-pay and Medicaid revenue shall be equivalent to at least four percent (4%), calculated as follows: the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue earned from self-pay and Medicaid cases, divided by the total earned revenues for all surgical cases, divided by the total earned revenues for all surgical cases performed in the facility for procedures for which there is a Medicare allowable fee.

(b) Each qualified urban ambulatory surgical facility shall annually report to the Department in the manner prescribed by the Department the percentage of the facility's earned revenue that is attributed to self-pay and Medicaid revenue, as calculated in accordance with subsection (a) of this section."

**SECTION 3.2.(d)** Subsections (a) through (c) of this section become effective two years from the date the Department of Health and Human Services (DHHS) issues the first directed payment in accordance with the Healthcare Access and Stabilization Program (HASP) under G.S. 108A-148.1, as enacted by Section 1.4 of this act, and applies to activities occurring on or after that date. The Secretary of Health and Human Services shall notify the Revisor of Statutes when the DHHS has issued the first directed payment in accordance with HASP and the date of issuance. If the DHHS has not made any HASP directed payments by June 30, 2025, then subsections (a) and (b) of this section shall expire on that date.

**SECTION 3.2.(e)** Except as otherwise provided, this section is effective when it becomes law.

**REFORMS EFFECTIVE THREE YEARS AFTER ISSUANCE OF THE FIRST HASP DIRECTED PAYMENT**

**SECTION 3.3.(a)** G.S. 131E-176, as amended by Sections 3.1 and 3.2 of this act, reads as rewritten:

"**§ 131E-176. Definitions.**

The following definitions apply in this Article:

…

(7a) Diagnostic center. – "Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds three million dollars ($3,000,000). No facility, program, or provider, including, but not limited to, physicians' offices, clinical laboratories, radiology centers, or mobile diagnostic programs, shall be deemed a diagnostic center solely by virtue of having a magnetic resonance imaging scanner in a county with a population of greater than 125,000 according to the 2020 federal decennial census or any subsequent federal decennial census. In determining whether the medical diagnostic equipment in a diagnostic center costs more than three million dollars ($3,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by

the U.S. Department of Labor for the 12-month period preceding the previous September 1.

…

(14o) Major medical equipment. – "Major medical equipment" means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than two million dollars ($2,000,000). In determining whether the major medical equipment costs more than two million dollars ($2,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment as defined in this ~~section.~~ section or magnetic resonance imaging scanners in counties with a population greater than 125,000 according to the 2020 federal decennial census or any subsequent federal decennial census. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

…

(16) New institutional health services. – Any of the following:

…

f1. The acquisition by purchase, donation, lease, transfer, or comparable arrangement of any of the following equipment by or on behalf of any person:

1. Air ambulance.
2. Repealed by Session Laws 2005-325, s. 1, effective for hospices and hospice offices December 31, 2005.
3. Cardiac catheterization equipment.
4. Gamma knife.
5. Heart-lung bypass machine.

5a. Linear accelerator.

6. Lithotriptor.
7. Magnetic resonance imaging scanner. This sub-sub-subdivision applies only to counties with a population of 125,000 or less according to the 2020 federal decennial census or any subsequent federal decennial census.
8. Positron emission tomography scanner.
9. Simulator.

…."

**SECTION 3.3.(b)** Subsection (a) of this section becomes effective three years from the date the Department of Health and Human Services (DHHS) issues the first directed payment in accordance with the Healthcare Access and Stabilization Program (HASP) under G.S. 108A-148.1, as enacted by Section 1.4 of this act, and applies to activities occurring on or after that date. The Secretary of Health and Human Services shall notify the Revisor of Statutes when DHHS has issued the first directed payment in accordance with HASP and the date of issuance. If the DHHS has not made any HASP directed payments by June 30, 2025, then subsection (a) of this section shall expire on that date.

**SECTION 3.3.(c)** Except as otherwise provided, this section is effective when it becomes law.

**SEVERABILITY OF PART III**

**SECTION 3.4.(a)** If any section or provision of this Part is declared unconstitutional or invalid by the courts, it does not affect the validity of this Part as a whole or any section or provision other than the section or provision so declared to be unconstitutional or invalid.

**SECTION 3.4.(b)** This section is effective when it becomes law.

**PART IV. EFFECTIVE DATE**

**SECTION 4.** Except as otherwise provided, this act is effective when it becomes law.