

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2025

**H.B. 1138**  
**Apr 29, 2026**  
**HOUSE PRINCIPAL CLERK**

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**HOUSE BILL DRH10581-MGa-149**

Short Title: Aging With Dignity Act.

(Public)

Sponsors: Representative Ball.

Referred to:

1 A BILL TO BE ENTITLED  
2 AN ACT PROMOTING AGING WITH DIGNITY BY STRENGTHENING HOME- AND  
3 COMMUNITY-BASED CARE; IMPROVING LONG-TERM CARE OVERSIGHT;  
4 SUPPORTING FAMILY CAREGIVERS AND THE GERIATRIC WORKFORCE;  
5 APPROPRIATING FUNDS FOR STRATEGIC STATE INVESTMENTS TO MEET THE  
6 NEEDS OF NORTH CAROLINA'S GROWING SENIOR POPULATION; AND  
7 REESTABLISHING A STUDY COMMISSION ON AGING.

8 The General Assembly of North Carolina enacts:

9  
10 **PART I. LEGISLATIVE FINDINGS**

11 **SECTION 1.1.** The General Assembly finds all of the following:

- 12 (1) North Carolina's population aged 65 and older is growing rapidly and is  
13 projected to exceed 2.4 million residents by 2030, significantly increasing  
14 demand for long-term services and supports.
- 15 (2) Older adults overwhelmingly prefer to remain in their homes and communities  
16 when appropriate, yet access to home- and community-based services is  
17 limited by workforce shortages, long waitlists, geographic disparities, and  
18 administrative barriers.
- 19 (3) Institutional long-term care is costly to individuals, families, and the State,  
20 while preventable hospitalizations, falls, medication-related injuries, and  
21 delayed discharges contribute to unnecessary Medicaid expenditures and  
22 strain the health care system.
- 23 (4) North Carolina relies on a direct care workforce that experiences low wages,  
24 high turnover, limited career advancement opportunities, and growing  
25 shortages that threaten access to safe and timely care for older adults.
- 26 (5) Family caregivers provide substantial unpaid care that reduces reliance on  
27 institutional care and public expenditures, yet frequently lack adequate  
28 financial support, respite services, and care coordination resources.
- 29 (6) The State has a responsibility to ensure that long-term care facilities operate  
30 with transparency, accountability, and a focus on resident dignity, safety, and  
31 quality of life and that regulatory and advocacy programs are adequately  
32 staffed and empowered to protect residents.
- 33 (7) Demographic trends, workforce constraints, and rising costs make  
34 continuation of current long-term care policies unsustainable without targeted  
35 reforms and strategic investments.



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- 1 (8) A coordinated policy framework that prioritizes aging in place when  
2 appropriate, strengthens oversight of long-term care settings, supports  
3 caregivers and the geriatric workforce, and invests in high-value,  
4 person-centered care is necessary to protect older North Carolinians and  
5 ensure responsible stewardship of public resources.  
6

7 **PART II. IMPROVEMENT OF LONG-TERM SERVICES & SUPPORTS FOR**  
8 **MEDICAID BENEFICIARIES**

9  
10 **HOME- AND COMMUNITY-BASED SERVICES PRESUMPTION FOR MEDICAID**  
11 **BENEFICIARIES**

12 SECTION 2.1. Part 6 of Article 2 of Chapter 108A of the General Statutes is  
13 amended by adding a new section to read:

14 **"§ 108A-70.5A. Presumption in favor of home- and community-based services for**  
15 **long-term services and supports.**

16 (a) Policy of the State. – It is the policy of the State that individuals aged 55 or older who  
17 require long-term services and supports funded in whole or in part by the medical assistance  
18 program should receive those services in the most integrated setting appropriate to their needs,  
19 consistent with federal law.

20 (b) Presumption Established. – Except as provided in subsection (e) of this section, for  
21 purposes of Medicaid-funded long-term services and supports, home- and community-based  
22 services shall be presumed to be the preferred setting of care unless institutional placement is  
23 determined to be medically necessary.

24 (c) Medical Necessity Determination. – An individual aged 55 or older may be placed in,  
25 or remain in, an institutional long-term care setting, including a nursing facility or a  
26 Medicaid-funded adult care home, only upon a documented determination that home- and  
27 community-based services are insufficient to meet the individual's assessed clinical, functional,  
28 or safety needs.

29 (d) Assessment and Documentation. – The determination required under subsection (c)  
30 of this section shall include all of the following:

31 (1) A standardized assessment approved by the Department.

32 (2) Written clinical justification supporting the need for institutional placement.

33 (3) A periodic reassessment at intervals established by the Department.

34 (e) Individual Choice. – Nothing in this section shall be construed to limit an individual's  
35 right to choose an institutional setting when otherwise eligible, provided the individual has been  
36 informed of available home- and community-based service options.

37 (f) Department Authority. – The Department shall implement this section and may adopt  
38 rules and policies necessary to carry out its provisions, including establishing clinical criteria,  
39 defining exceptions, and seeking any necessary federal approvals, waivers, or amendments to the  
40 Medicaid State Plan."  
41

42 **POLYPHARMACY REVIEW FOR MEDICAID BENEFICIARIES RECEIVING**  
43 **LONG-TERM SERVICES AND SUPPORTS**

44 SECTION 2.2. Part 6 of Article 2 of Chapter 108A of the General Statutes is  
45 amended by adding a new section to read:

46 **"§ 108A-70.5B. Medication review for individuals receiving long-term services and**  
47 **supports.**

48 (a) Findings and Purpose. – The General Assembly finds that the use of multiple  
49 concurrent medications is associated with increased risk of falls, cognitive impairment,  
50 hospitalization, and diminished quality of life among older adults. The purpose of this section is

1 to reduce preventable harm and unnecessary health care expenditures by ensuring regular,  
2 comprehensive medication review for individuals receiving long-term services and supports.

3 (b) Medication Review Required. – The Department shall ensure that individuals aged  
4 55 or older receiving Medicaid-funded long-term services and supports are provided periodic  
5 medication reviews to identify potentially inappropriate medications, duplicative therapies,  
6 adverse drug interactions, and opportunities for medication optimization.

7 (c) Scope of Review. – Medication reviews under this section shall include all of the  
8 following:

9 (1) A review of all prescription medications and, to the extent feasible,  
10 over-the-counter medications and supplements known to be used by the  
11 individual.

12 (2) A consideration of the cumulative medication burden, drug-drug interactions,  
13 and drug-condition interactions.

14 (3) An evaluation of medications associated with increased risk of falls, sedation,  
15 confusion, or functional decline.

16 (4) Documentation in the individual's care record.

17 (d) Qualified Reviewers. – Medication reviews shall be conducted by a licensed  
18 pharmacist, physician, or other qualified health care professional authorized by the Department  
19 and acting within the scope of licensure.

20 (e) Deprescribing Authority. – The Department may adopt rules to allow for  
21 deprescribing or medication modification when clinically appropriate, including processes for  
22 communication and coordination among prescribers, pharmacists, care managers, and the  
23 individual or the individual's representative.

24 (f) Integration with Care Planning. – Medication review findings under this section shall  
25 be incorporated into the individual's care plan and used to inform service authorization, care  
26 coordination, and reassessment decisions.

27 (g) Implementation Flexibility. – The Department may implement this section through  
28 managed care contracts, clinical policy, or other administrative mechanisms and may prioritize  
29 implementation for individuals at highest risk of medication-related harm."  
30

## 31 INTEGRATION OF BEHAVIORAL HEALTH AND GERIATRIC CARE FOR 32 MEDICAID BENEFICIARIES

33 SECTION 2.3. Part 6 of Article 2 of Chapter 108A of the General Statutes is  
34 amended by adding a new section to read:

35 "**§ 108A-70.5C. Integration of behavioral health services for older adults receiving**  
36 **long-term services and supports.**

37 (a) Purpose. – The purpose of this section is to ensure that older adults receiving  
38 Medicaid-funded long-term services and supports have access to age-appropriate,  
39 dementia-capable behavioral health services in order to improve quality of life, reduce  
40 preventable hospitalizations, and decrease reliance on inappropriate sedation or chemical  
41 restraint.

42 (b) Integration Requirement. – The Department shall ensure that behavioral health  
43 assessment, treatment, and care coordination are integrated into the delivery of Medicaid-funded  
44 long-term services and supports for adults aged 55 or older, including individuals with dementia  
45 or cognitive impairment.

46 (c) Scope of Services. – Behavioral health integration under this section shall include all  
47 of the following:

48 (1) Screening and assessment for depression, anxiety, dementia-related  
49 behavioral symptoms, and other geriatric behavioral health needs.

50 (2) Access to mental health and substance use disorder services delivered by  
51 clinicians with training or experience in geriatric care.

1           (3) Dementia-capable behavioral health interventions designed to address  
2 behavioral symptoms without unnecessary reliance on pharmacological  
3 treatment.

4           (4) Care coordination among primary care providers, behavioral health providers,  
5 pharmacists, and long-term services and supports providers.

6           (5) Crisis intervention strategies that reduce avoidable emergency department  
7 visits and hospitalizations.

8           (d) Medication Practices. – The Department shall promote care models and clinical  
9 practices that prioritize nonpharmacological and person-centered interventions for behavioral  
10 symptoms in adults aged 55 or older and shall discourage the use of antipsychotics, sedatives, or  
11 other medications when not clinically indicated.

12           (e) Implementation. – The Department may adopt rules to implement this section through  
13 clinical policy, managed care contracts, provider standards, care management requirements, or  
14 other administrative mechanisms and may prioritize implementation for individuals at highest  
15 risk of behavioral health-related hospitalization or institutional placement.

16           (f) Training and Workforce Support. – The Department may support training and  
17 technical assistance for providers and care managers to build geriatric behavioral health and  
18 dementia-capable care expertise."

## 20 **RECOGNITION OF SOCIAL ISOLATION AND LONELINESS IN CARE PLANNING** 21 **FOR OLDER ADULT MEDICAID BENEFICIARIES**

22           **SECTION 2.4.** Part 6 of Article 2 of Chapter 108A of the General Statutes is  
23 amended by adding a new section to read:

24 **"§ 108A-70.5D. Screening for social isolation and loneliness; care coordination and**  
25 **referral.**

26           (a) Purpose. – The purpose of this section is to improve early identification and  
27 intervention for social isolation and loneliness among older adults receiving Medicaid-funded  
28 long-term services and supports in order to prevent avoidable health decline, functional  
29 impairment, and progression to more serious mental health conditions.

30           (b) Screening Authorized. – The Department shall authorize and promote screening for  
31 social isolation and loneliness among adults aged 55 or older receiving Medicaid-funded  
32 long-term services and supports, using evidence-based screening tools approved by the  
33 Department.

34           (c) Care Coordination and Referral. – When screening indicates significant social  
35 isolation or loneliness, the Department shall ensure that those findings may be used to do any of  
36 the following:

37                   (1) Trigger care coordination activities.

38                   (2) Prompt referral for further clinical evaluation, including behavioral health  
39 assessment when appropriate.

40                   (3) Inform individualized care planning and service authorization decisions.

41           (d) Covered Services. – Social isolation and loneliness, when identified through  
42 authorized screening, shall be recognized as valid factors for purposes of Medicaid-funded care  
43 coordination, assessment, and referral services. Nothing in this section shall be construed to  
44 require coverage of room and board or nonmedical housing costs.

45           (e) Clinical Evaluation Not Precluded. – A finding of social isolation or loneliness shall  
46 not be used as a substitute for clinical evaluation. The Department shall ensure that symptoms  
47 associated with loneliness are appropriately addressed and, when indicated, evaluated for  
48 depression, anxiety, cognitive impairment, or other diagnosable conditions.

49           (f) Implementation. – The Department may adopt rules to implement this section through  
50 clinical policy, care management requirements, managed care contracts, or other administrative

1 mechanisms and may prioritize implementation for individuals at higher risk of hospitalization,  
2 functional decline, or institutional placement."

3  
4 **PART III. APPROPRIATIONS FOR STRATEGIC STATE INVESTMENTS TO MEET**  
5 **THE NEEDS OF NORTH CAROLINA'S GROWING SENIOR POPULATION**

6  
7 **INTEGRATED SENIOR HOUSING AND CARE PILOT PROGRAM**

8 **SECTION 3.1.(a)** The Department of Health and Human Services shall establish  
9 and conduct an integrated senior housing and care pilot program (pilot program). The purpose of  
10 the pilot program is to initiate a public-private partnership to plan, design, construct, and launch  
11 a housing-first residential facility that integrates on-site medical, behavioral health, pharmacy,  
12 rehabilitative, and supportive services for older adults who rely heavily on Medicare and  
13 Medicaid services.

14 **SECTION 3.1.(b)** In designing, constructing, and launching the housing-first  
15 residential facility for use in the pilot program, the Department of Health and Human Services  
16 and any entity selected to partner with the Department of Health and Human Services shall adhere  
17 to all of the following requirements:

- 18 (1) The facility shall consist of not more than 300 residential units located at a  
19 single site.
- 20 (2) The facility shall be operated as housing-first, with residents retaining tenancy  
21 rights and receiving health and supportive services through integrated on-site  
22 or affiliated providers.
- 23 (3) The facility shall be designed to serve individuals who are dually eligible for  
24 Medicare and Medicaid, and participation in Medicaid-funded services is a  
25 condition of all pilot program participants, including facility residents and  
26 entities that partner with the Department of Health and Human Services to  
27 operate the facility.
- 28 (4) The facility shall be designed to reduce care fragmentation and unnecessary  
29 transitions by providing coordinated, interdisciplinary services on-site or  
30 through formal partnerships.

31 **SECTION 3.1.(c)** The Department of Health and Human Services is authorized to  
32 do all of the following to establish and conduct the pilot program:

- 33 (1) Implement a selection process for contracting with one or more nonprofit  
34 organizations, local governments, or private entities to design, construct,  
35 launch, and operate the facility.
- 36 (2) Structure the pilot program as a public-private partnership by leveraging both  
37 public and private sector expertise and a mixture of funding sources, including  
38 public sector grants, loans provided by public or private institutions or both,  
39 and other financing mechanisms.
- 40 (3) Coordinate with other State agencies and seek federal approvals, waivers, or  
41 financing mechanisms to support the pilot program.
- 42 (4) Adopt rules as necessary to carry out the pilot program.

43 **SECTION 3.1.(d)** There is appropriated from the General Fund to the Department  
44 of Health and Human Services the sum of one hundred twenty million dollars (\$120,000,000) in  
45 nonrecurring funds for the 2026-2027 fiscal year to establish and conduct the integrated senior  
46 housing and care pilot program authorized by this section. Funds appropriated by this subsection  
47 shall not be used for any purposes other than the following:

- 48 (1) Site acquisition, planning, and design costs.
- 49 (2) Predevelopment and construction costs.
- 50 (3) Capital costs necessary to integrate on-site clinical and supportive service  
51 capacity.

- 1 (4) Start-up and initial operating costs, including those associated with staffing,  
2 care coordination infrastructure, and program launch expenses, as determined  
3 necessary by the Department of Health and Human Services.

4 Notwithstanding G.S. 143C-1-2(b) or any other provision of law to the contrary,  
5 funds appropriated by this subsection shall not revert at the end of the 2026-2027 fiscal year but  
6 shall remain available for the purposes authorized by this subsection until expended.

7 **SECTION 3.1.(e)** Beginning May 1, 2028, and annually thereafter for as long as  
8 funds appropriated by this section remain available for expenditure, the Department of Health  
9 and Human Services shall report to the Joint Legislative Oversight Committee on Health and  
10 Human Services and the Fiscal Research Division on the implementation status and operation of  
11 the integrated senior housing and care pilot program authorized by this section. Beginning one  
12 year after initial occupancy of the housing-first residential facility funded by subsection (d) of  
13 this section, the report required by this section shall include at least all of the following  
14 information regarding the occupants of that residential facility:

- 15 (1) The number of residents and their demographic data, including, at a minimum,  
16 their age and sex.  
17 (2) Medicaid and Medicare utilization trends.  
18 (3) Rates of hospitalization, institutional placement, and transitions of care.  
19 (4) Quality-of-life and resident satisfaction measures.  
20 (5) Lessons learned and recommendations regarding scalability or replication of  
21 this pilot program.

22 **SECTION 3.1.(f)** The pilot program authorized by this section terminates at the end  
23 of the fiscal year in which the funds appropriated pursuant to subsection (d) of this section are  
24 expended.

## 25 **STRENGTHENING THE LONG-TERM CARE OMBUDSMAN PROGRAM**

26 **SECTION 3.2.(a)** The Department of Health and Human Services, Division of  
27 Aging, Office of the State Long-Term Care Ombudsman, shall work toward strengthening the  
28 State Long-Term Care Ombudsman Program (Ombudsman Program) by improving access to  
29 Ombudsman Program services; reducing the backlog of complaints received by the Ombudsman  
30 Program; improving response times in high-priority cases involving immediate threats to the  
31 health, safety, or rights of residents in long-term care facilities; and enhancing coordination with  
32 other entities responsible for protecting the rights of residents in long-term care facilities,  
33 regulating long-term care facilities, or a combination of those.

34 **SECTION 3.2.(b)** No later than January 1, 2027, the Department of Health and  
35 Human Services, Division of Aging, Office of the State Long-Term Care Ombudsman, shall  
36 develop and begin implementing a staffing and regional coverage plan for the Ombudsman  
37 Program that accomplishes all of the following:

- 38 (1) Identifies staffing vacancies, workload pressures, and regional service gaps.  
39 (2) Establishes priorities for hiring additional State and regional ombudsman  
40 personnel.  
41 (3) Improves timely on-site response capacity in high-priority cases.  
42 (4) Supports complaint intake, complaint investigation, complaint resolution, and  
43 follow-up.  
44 (5) Provides for training, travel, case management, and administrative support for  
45 State and regional ombudsman personnel as necessary to fulfill the objectives  
46 of the Ombudsman Program.  
47

48 **SECTION 3.2.(c)** There is appropriated from the General Fund to the Department  
49 of Health and Human Services, Division of Aging, Office of the State Long-Term Care  
50 Ombudsman, the sum of three million five hundred thousand dollars (\$3,500,000) in recurring  
51 funds beginning in the 2026-2027 fiscal year to improve the Ombudsman Program as specified

1 in subsection (a) of this section and to implement the staffing and regional coverage plan  
 2 described in subsection (b) of this section. Funds appropriated by this subsection shall not be  
 3 used for any purposes other than the following:

- 4 (1) Hiring additional State and regional ombudsman personnel.
- 5 (2) Expanding access to the Ombudsman Program, complaint intake,  
 6 investigation, resolution, and follow-up capacity.
- 7 (3) Supporting travel, training, case management systems, and administrative  
 8 functions for State and regional ombudsman personnel.
- 9 (4) Strengthening coordination with the Division of Health Service Regulation;  
 10 county departments of social services; Adult Protective Services; legal  
 11 services providers; and other entities responsible for the protection of  
 12 residents in long-term care facilities, the regulation of long-term care  
 13 facilities, or a combination of those.
- 14 (5) Reducing complaint backlogs and improving response times in high-priority  
 15 cases.
- 16 (6) Supporting data collection, reporting, and program administration necessary  
 17 to carry out this section.

18 **SECTION 3.2.(d)** No later than December 1, 2027, and annually thereafter, the  
 19 Department of Health and Human Services, Division of Aging, Office of the State Long-Term  
 20 Care Ombudsman, shall submit a report to the Joint Legislative Oversight Committee on Health  
 21 and Human Services and the Fiscal Research Division on the implementation status of this  
 22 section. The report shall include at least all of the following information regarding the activities  
 23 of the Ombudsman Program:

- 24 (1) The number and type of complaints received.
- 25 (2) Average response times and average resolution times.
- 26 (3) Complaint backlogs, staffing vacancies, and regional coverage gaps.
- 27 (4) Referrals made to regulatory, protective, or law enforcement agencies.
- 28 (5) The use of funds appropriated by subsection (c) of this section.
- 29 (6) Any recommendations for administrative or legislative action.

30  
 31 **GERIATRIC WORKFORCE PIPELINE AND DIRECT CARE CAREER**  
 32 **ADVANCEMENT PROGRAM**

33 **SECTION 3.3.(a)** Article 3 of Chapter 143B of the General Statutes is amended by  
 34 adding a new section to read:

35 **"§ 143B-181.27. Geriatric workforce pipeline and direct care career advancement**  
 36 **program.**

37 (a) The Department of Health and Human Services (DHHS), in consultation with the  
 38 North Carolina Community Colleges System Office, The University of North Carolina System  
 39 Office, the North Carolina Independent Colleges and Universities, the Department of Commerce,  
 40 and relevant licensing boards, shall establish a geriatric workforce pipeline and direct care career  
 41 advancement program (the program). The purpose of the program is to increase the supply,  
 42 geographic distribution, retention, and advancement of workers prepared to serve older adults in  
 43 a diversity of settings, including home- and community-based settings, nursing facilities, adult  
 44 care homes, and hospitals.

45 (b) The program shall be designed to achieve all of the following goals:

- 46 (1) Establish geriatric care training pathways for nurses, physicians, social  
 47 workers, pharmacists, behavioral health professionals, direct care workers,  
 48 and other relevant personnel.
- 49 (2) Establish partnerships with community colleges and employers to create  
 50 stackable, portable credentials for direct care workers and other frontline  
 51 personnel serving older adults.

- 1           (3)    Establish career ladder models that support advancement from entry-level  
2           direct care roles into more specialized or higher-paid roles.
- 3           (4)    Implement recruitment initiatives targeted to rural counties, underserved  
4           communities, and areas experiencing workforce shortages in geriatric and  
5           long-term care settings.
- 6           (5)    Establish clinical training, apprenticeships, preceptorships, internships, or  
7           other work-based learning opportunities in geriatric and long-term care  
8           settings.
- 9           (6)    Improve retention supports for the geriatric workforce, including mentoring,  
10          supervision, and continuing education.
- 11          (7)    Elicit recommendations for the modernization of scope-of-practice laws,  
12          rules, or supervision requirements, where appropriate, to improve access to  
13          safe and timely geriatric care while maintaining patient protections.
- 14          (c)    Subject to available appropriations, the program may fund loan forgiveness,  
15          forgivable loans, tuition assistance, or similar incentives for eligible individuals who commit to  
16          practicing in geriatric, long-term care, or direct care service settings in this State for a minimum  
17          period of time established by the DHHS.
- 18          (d)    In administering the program, the DHHS shall prioritize workforce investments that  
19          expand service capacity for Medicaid beneficiaries, individuals with dementia, family caregiver  
20          support programs, and older adults residing in rural or high-need areas.
- 21          (e)    Credentials developed under this program shall, to the extent practicable, be  
22          recognized across participating employers and training institutions in order to facilitate worker  
23          mobility, advancement, and retention.
- 24          (f)    No later than October 1 of each year, the DHHS shall report to the Joint Legislative  
25          Oversight Committee on Health and Human Services, the Joint Legislative Education Oversight  
26          Committee, and the Fiscal Research Division on the implementation status and operation of the  
27          program. The report shall include, at a minimum, the following information:
- 28               (1)    Enrollment data for all training and education pathways developed under the  
29               program.
- 30               (2)    A description of any stackable, portable credentials developed under the  
31               program for direct care workers and other frontline personnel serving older  
32               adults and the number of individuals who obtained these credentials.
- 33               (3)    The number of vacancies filled as a result of the program.
- 34               (4)    An evaluation of the retention rates of direct care workers and other frontline  
35               personnel as a result of the program.
- 36               (5)    Any recommended legislative changes to improve program administration or  
37               to increase the supply, geographic distribution, retention, and advancement of  
38               workers prepared to serve older adults in a diversity of settings.
- 39          (g)    Rules. – The DHHS may adopt rules to implement the program."

40          **SECTION 3.3.(b)** There is appropriated from the General Fund to the Department  
41 of Health and Human Services the sum of ten million dollars (\$10,000,000) in recurring funds  
42 beginning in the 2026-2027 fiscal year to implement the geriatric workforce pipeline and direct  
43 care career advancement program authorized by G.S. 143B-181.27, as enacted by subsection (a)  
44 of this section.

#### 45 **FAMILY CAREGIVER SUPPORT STIPEND PILOT PROGRAM**

46          **SECTION 3.4.(a)** The purpose of the proposed family caregiver support stipend  
47 pilot program (the pilot program) is to reduce caregiver burnout, delay or prevent avoidable  
48 institutionalization, and support older adults who choose to remain in their homes and  
49 communities by authorizing a targeted Medicaid-funded family caregiver support stipend,  
50 subject to federal approval and available appropriations.  
51

1           **SECTION 3.4.(b)** The Department of Health and Human Services, Division of  
2 Health Benefits (DHB), is directed to take all actions necessary to support implementation of the  
3 pilot program for eligible family caregivers of Medicaid beneficiaries receiving long-term  
4 services and supports that meets the requirements of this section, including, as applicable,  
5 submitting any necessary documentation to the Centers for Medicare and Medicaid Services  
6 (CMS), including State Plan Amendments and waiver amendments.

7           **SECTION 3.4.(c)** DHB shall only implement the pilot program described in this  
8 section if any necessary submissions to CMS under subsection (b) of this section are approved.

9           **SECTION 3.4.(d)** The monthly stipend provided under the pilot program shall be a  
10 maximum of four hundred dollars (\$400.00) to each eligible family caregiver per eligible care  
11 recipient.

12           **SECTION 3.4.(e)** DHB shall adopt rules or clinical coverage policies, as  
13 appropriate, establishing eligibility criteria for care recipients and family caregivers for the pilot  
14 program, that shall include at least all of the following:

- 15           (1) The care recipient is an older adult or other individual receiving  
16 Medicaid-funded long-term services and supports who would, in the absence  
17 of caregiver support, be at increased risk of hospitalization, institutional  
18 placement, or other higher-cost care.
- 19           (2) The care recipient is living in a home- or community-based setting.
- 20           (3) The family caregiver provides substantial assistance with activities of daily  
21 living, instrumental activities of daily living, supervision, or other support  
22 identified by DHB.
- 23           (4) The family caregiver satisfies any training, documentation, and program  
24 integrity requirements established by DHB.

25           **SECTION 3.4.(f)** DHB shall adopt rules or clinical coverage policies, as appropriate,  
26 establishing guardrails for the pilot program, which may include any of the following:

- 27           (1) Limits on duplication of payment where the family caregiver is otherwise  
28 compensated through another Medicaid service category for the same service.
- 29           (2) Documentation requirements of caregiving activities.
- 30           (3) Family caregiver training requirements.
- 31           (4) Care assessments and periodic reassessments.
- 32           (5) Fraud prevention and recovery procedures.
- 33           (6) Safeguards to protect beneficiary choice, health, safety, and quality of care.

34           **SECTION 3.4.(g)** No later than six months after receiving any federal approval on  
35 any submissions under subsection (b) of this section, and annually thereafter for any year in  
36 which the pilot program is implemented under this section, DHB shall report to the Joint  
37 Legislative Oversight Committee on Medicaid and the Fiscal Research Division. This report shall  
38 include all of the following, as applicable:

- 39           (1) An overview of implementation activities.
- 40           (2) The number of family caregivers and care recipients participating in the pilot  
41 program.
- 42           (3) An overview of total expenditures on the pilot program.
- 43           (4) An evaluation of the pilot program outcomes with respect to all of the  
44 following:
  - 45           a. Caregiver burden.
  - 46           b. Beneficiary satisfaction.
  - 47           c. Avoidable hospitalizations.
  - 48           d. Nursing facility admissions.
  - 49           e. Medicaid cost avoidance.
  - 50           f. Other measures as DHB deems appropriate.
- 51           (5) Any recommended legislative changes.

1           **SECTION 3.4.(h)** Nothing in this section shall be construed to create an entitlement  
2 to a stipend absent federal approval and an appropriation enacted by the General Assembly.

3           **SECTION 3.4.(i)** There is appropriated from the General Fund to DHB the sum of  
4 thirteen million five hundred thousand dollars (\$13,500,000) in recurring funds beginning in the  
5 2026-2027 fiscal year and the sum of seven hundred fifty thousand dollars (\$750,000) in  
6 nonrecurring funds for the 2026-2027 fiscal year to be used to implement this section. The funds  
7 appropriated under this subsection shall not be used for any other purpose and shall revert at the  
8 end of the fiscal year in which they are appropriated if not expended.

9           **SECTION 3.4.(j)** This section shall expire two years after it becomes law.

#### 10 11 **PART IV. REESTABLISHMENT OF STUDY COMMISSION ON AGING**

12           **SECTION 4.1.(a)** Commission Created; Purpose. – There is created the Aging Study  
13 Commission (Commission) for the purpose of studying and recommending legislative and policy  
14 changes necessary for North Carolina to respond to the needs of its aging population, particularly  
15 as the first wave of the baby boom generation reaches advanced age beginning in 2026.

16           **SECTION 4.1.(b)** Duties. – In studying and recommending legislative policy  
17 changes necessary for North Carolina to respond to the needs of its aging population, the  
18 Commission shall examine at least all of the following issues related to aging:

- 19           (1) Long-term services and supports, including home- and community-based  
20 services and institutional care.
- 21           (2) Workforce capacity and training for geriatric and direct care professions.
- 22           (3) Support for family caregivers.
- 23           (4) Housing, transportation, and community infrastructure necessary to support  
24 aging in place.
- 25           (5) Accessibility and quality of health care for older adults, including integrated  
26 behavioral health and dementia-capable services.
- 27           (6) Financing and sustainability of services for older adults, including through  
28 Medicaid and other programs of public assistance.
- 29           (7) Oversight, quality, and accountability in long-term care settings.
- 30           (8) Legislative proposals to implement the findings of the Governor's Advisory  
31 Council on Aging.

32           **SECTION 4.1.(c)** Membership. – The Commission shall consist of the following 15  
33 voting members and five ex officio, nonvoting members:

- 34           (1) Six members appointed by the President Pro Tempore of the Senate; the  
35 persons appointed may be members of the Senate or public members.
- 36           (2) Six members appointed by the Speaker of the House of Representatives; the  
37 persons appointed may be members of the House of Representatives or public  
38 members.
- 39           (3) Three public members appointed by the Governor.
- 40           (4) The following ex officio, nonvoting members or their designees:
  - 41           a. The Secretary of the Department of Health and Human Services.
  - 42           b. The Director of the Division of Aging.
  - 43           c. The Director of the Division of Health Benefits.
  - 44           d. The Secretary of Commerce.
  - 45           e. A representative of the Governor's Council on Aging.

46           Appointing authorities may consider geographic diversity and subject-matter  
47 expertise when making their appointments. Any vacancies on the Commission shall be filled by  
48 the original appointing authorities.

49           **SECTION 4.1.(d)** Meetings. – The Commission shall meet at the call of the cochairs.  
50 The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall  
51 each designate one cochair from among the legislative members.

1           **SECTION 4.1.(e)** Staffing and Assistance. – The Legislative Services Office shall  
2 provide staff support to the Commission. The Commission may request assistance from State  
3 agencies, academic institutions, and subject-matter experts as necessary to carry out its duties.

4           **SECTION 4.1.(f)** Report. – The Commission shall submit a report of its findings  
5 and recommendations, including any recommended legislation, to the General Assembly no later  
6 than December 31, 2027.

7           **SECTION 4.1.(g)** Sunset. – The Commission shall terminate upon the submission  
8 of its report to the General Assembly, unless extended by an act of the General Assembly.

9  
10 **PART V. EFFECTIVE DATE**

11           **SECTION 5.1.** Except as otherwise provided, this act is effective July 1, 2026.