Article 2.

Programs of Public Assistance.

Part 1. In General.

**§ 108A-24. Definitions.**

As used in Chapter 108A:

(1) "Applicant" is any person who requests assistance or on whose behalf assistance is requested.

(1a) Repealed by Session Laws 2001-424, s. 21.52.

(1b) "Community service" means work exchanged for temporary public assistance.

(1c) "County block grant" means federal and State money appropriated to implement and maintain a county's Work First Program.

(1d) "County department of social services" means a county department of social services, consolidated human services agency, or other local agency designated to administer services pursuant to this Article.

(1e) "County Plan" is the biennial Work First Program plan prepared by each Electing County pursuant to this Article and submitted to the Department for incorporation into the State Plan that also includes the Standard Work First Program.

(2) "Department" is the Department of Health and Human Services, unless the context clearly indicates otherwise.

(3) "Dependent child" is a person 17 years of age or younger or, in the medical assistance program, a person under 19 years of age. A child 18 years of age, if in high school and expected to graduate by his or her 19th birthday, may receive Work First benefits through the month he or she turns 19 years of age or graduates from high school, whichever comes first.

(3a) "Electing County" means a county that elects to develop and is approved to administer a local Work First Program.

(3b) "Employment" means work that requires either a contribution to FICA or the filing of a State N.C. Form D-400, or the equivalent.

(3c) "Family" means a unit consisting of a minor child or children and one or more of their biological parents, adoptive parents, stepparents, or grandparents living together. For purposes of the Work First Program, family also includes a blood or half-blood relative or adoptive relative limited to brother, sister, great-grandparent, great-great-grandparent, uncle, aunt, great-uncle, great-aunt, great-great-uncle, great-great-aunt, nephew, niece, first cousin, stepbrother, and stepsister.

(3d) "Federal TANF funds" means the Temporary Assistance for Needy Families block grant funds provided for in Title IV-A of the Social Security Act.

(3e) **(Effective until contingency met – see note)** "Fee-for-service program" means a payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice recipients rather than contracting for the coverage of services through a capitated payment arrangement.

(3e) **(Effective once contingency met – see note)** "Fee-for-service program" means a payment model for the Medicaid program operated by the Department of Health and Human Services pursuant to its authority under Part 6 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid recipients rather than contracting for the coverage of services through a capitated payment arrangement.

(3f) Repealed by Session Laws 2009-489, s. 1, effective August 26, 2009.

(3g) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.

(3h) "Full-time employment" means employment which requires the employee to work a regular schedule of hours per day and days per week established as the standard full-time workweek by the employer, but not less than an average of 30 hours per week.

(4) Repealed by Session Laws 1983, c. 14, s. 3.

(4a) "Mutual Responsibility Agreement" ("MRA") is an agreement between a county and a recipient of Work First Program assistance which describes the conditions for eligibility for the assistance and what the county will provide to assist the recipient in moving from assistance to self-sufficiency. A MRA may provide for recipient parental responsibilities and child development goals and what a county or the State will provide to assist the recipient in achieving those child development goals. Improvement in literacy shall be a part of any MRA, but a recipient shall not be penalized if unable to achieve improvement. A MRA is a prerequisite for any Work First Program assistance under this Article.

(4b) "Parent" means biological parent or adoptive parent, and for Work First purposes, includes a stepparent.

(4c) "Prepaid health plan" or "PHP" has the same meaning as in G.S. 108D-1.

(5) "Recipient" is a person to whom, or on whose behalf, assistance is granted under this Article.

(6) "Resident," unless otherwise defined by federal regulation, is a person who is living in North Carolina at the time of application with the intent to remain permanently or for an indefinite period; or who is a person who enters North Carolina seeking employment or with a job commitment.

(7) "Secretary" is the Secretary of Health and Human Services, unless the context clearly indicates otherwise.

(8) "Standard Program County" means a county that participates in the Standard Work First Program.

(9) "Standard Work First Program" means the Work First Program developed by the Department.

(10) "State Plan" is the biennial Work First Program plan, based upon the aggregate of the Electing County Plans and the Standard Work First Program, prepared by the Department for the State's Work First Program pursuant to this Article, and submitted sequentially to the Budget Director, to the General Assembly, to the Governor, and to the appropriate federal officials for approval.

(11) "Temporary" is a time period, not to exceed 60 cumulative months, which meets the federal requirement of Title IV-A.

(12) "Title IV-A" means the Social Security Act, 42 U.S.C. § 601, et seq., as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193, as further amended by the Deficit Reduction Act of 2005, P.L. 109-171 and to other provisions of federal law as may apply to assistance provided in this Article.

(13) "Work" is lawful activity exchanged for cash, goods, uses, or services.

(14) "Work First Diversion Assistance" is a short-term cash payment that is intended to substantially reduce the likelihood of a family requiring Work First Family Assistance. Work First Diversion Assistance must be used to address a specific family crisis or episode of need and may not be used for ongoing or recurrent needs. Work First Diversion Assistance is limited to once in a 12-month period.

(15) "Work First Family Assistance" is a program of time-limited periodic payments to assist in maintaining the children of eligible families while the adult family members engage in activities to prepare for entering and to enter the workplace.

(16) "Work First Program" is the Temporary Assistance for Needy Families program established in this Article.

(17) "Work First Program assistance" means the goods or services provided under the Work First Program.

(18) "Work First Services" are services funded from appropriations made pursuant to this Article and designed to facilitate the purposes of the Work First Program. (1981, c. 275, s. 1; 1983, c. 14, s. 3; 1997-443, ss. 11A.118(a), 12.2; 2001-424, s. 21.52; 2009-489, s. 1; 2019-81, s. 3; 2022-74, s. 9D.15(f).)

**§ 108A-25. Creation of programs; assumption by federally recognized tribe of programs.**

(a) The following programs of public assistance are established, and shall be administered by the county department of social services or the Department of Health and Human Services under federal regulations or under rules adopted by the Social Services Commission and under the supervision of the Department of Human Resources:

(1) Repealed by S.L. 1997-443, s. 12.3, effective August 28, 1997.

(2) State-county special assistance.

(3) Food and Nutrition Services.

(4) Foster care and adoption assistance payments.

(5) Low income energy assistance program.

(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.

(b1) The Work First Program is established as a program of public assistance and shall be supervised and administered as provided in Part 2 of this Article.

(c) The Department of Health and Human Services may accept all grants-in-aid for programs of public assistance which may be available to the State by the federal government. The provisions of this Article shall be liberally construed in order that the State and its citizens may benefit fully from the federal grants-in-aid.

(d) Each Community Care network organization designated by the Department of Health and Human Services as responsible for coordinating the health care of individuals eligible for medical assistance in a county is hereby deemed to be a public agency that is a local unit of

government for the sole and limited purpose of all grants-in-aid, public assistance grant programs, and other funding programs.

(e) **(Effective until contingency met – see note)** When any federally recognized Native American tribe within the State assumes responsibility for any social services, Medicaid and NC Health Choice healthcare benefit programs, and ancillary services, including Medicaid administrative and service functions, that are otherwise the responsibility of a county under State law, then, notwithstanding any other provision of law, the county shall be relieved of the legal responsibility related to the tribe's assumption of those services. With respect to a tribe's assumption of any responsibilities for administration of any aspects of the NC Medicaid program, NC Health Choice, and the Supplemental Nutrition Assistance Program (SNAP), the State and the tribe shall execute an agreement to set forth the general terms, definitions, and conditions by which the parties shall operate. The agreement shall also include requirements and procedures regarding the allocation of all federal and other funds for all programs to be administered by the tribe. Upon the execution of the agreement, to allow the tribe to assume certain duties and responsibilities for the administration of the NC Medicaid program, NC Health Choice, and SNAP, the agreement between the State and the tribe shall require the tribe to accept the oversight authority of the State and the Department of Health and Human Services (Department) in the administration and supervision of these programs. In addition to the other necessary terms and conditions, the agreement shall include the following conditions:

(1) All requirements as prescribed by federal law, as well as the tribe and State's responsibilities in complying with federal law, including, but not limited to, any specific provisions pertaining to accounting and auditing compliance, maintenance of liability insurance, confidentiality, reporting requirements, indemnity, waiver of immunity, or due process.

(2) As the Department is the federally recognized single State agency for the NC Medicaid program, NC Health Choice, and SNAP, provisions stating the Department retains ultimate administrative discretion in the administration interpretation of all applicable policies, rules, and regulations regarding application processing, eligibility determinations and redeterminations, and other functions related to the eligibility process.

(3) Provisions by the tribe to ensure that individuals who will be responsible for the tribe's duties and responsibilities under this agreement shall be employed under standards equivalent to current standards for a Merit System of Personnel Administration or any standards later prescribed by the Office of Personnel Management under section 208 of the Intergovernmental Personnel Act of 1970, unless an exemption is obtained from the federal government. The tribe shall also provide the Department with information to verify the unemployment standards included under this condition.

(4) Requirements and procedures for allocating to the tribe in a timely manner all federal funds, nonfederal matching funds, and State funds for State programs previously borne by the State. However, requirements and procedures for allocating funds pursuant to this subdivision shall not include any funding the tribe receives directly from federal agencies.

(5) The Department shall, when possible and as allowed by the federal government, adopt funding flexibility for Indian Health Services when such flexibility furthers goals addressing health disparities among American Indians.

(e) **(Effective once contingency met – see note)** When any federally recognized Native American tribe within the State assumes responsibility for any social services, Medicaid healthcare benefit programs, and ancillary services, including Medicaid administrative and service functions, that are otherwise the responsibility of a county under State law, then, notwithstanding any other provision of law, the county shall be relieved of the legal responsibility related to the tribe's assumption of those services. With respect to a tribe's assumption of any responsibilities for administration of any aspects of the NC Medicaid program and the Supplemental Nutrition Assistance Program (SNAP), the State and the tribe shall execute an agreement to set forth the general terms, definitions, and conditions by which the parties shall operate. The agreement shall also include requirements and procedures regarding the allocation of all federal and other funds for all programs to be administered by the tribe. Upon the execution of the agreement, to allow the tribe to assume certain duties and responsibilities for the administration of the NC Medicaid program and SNAP, the agreement between the State and the tribe shall require the tribe to accept the oversight authority of the State and the Department of Health and Human Services (Department) in the administration and supervision of these programs. In addition to the other necessary terms and conditions, the agreement shall include the following conditions:

(1) All requirements as prescribed by federal law, as well as the tribe and State's responsibilities in complying with federal law, including, but not limited to, any specific provisions pertaining to accounting and auditing compliance, maintenance of liability insurance, confidentiality, reporting requirements, indemnity, waiver of immunity, or due process.

(2) As the Department is the federally recognized single State agency for the NC Medicaid program and SNAP, provisions stating the Department retains ultimate administrative discretion in the administration interpretation of all applicable policies, rules, and regulations regarding application processing, eligibility determinations and redeterminations, and other functions related to the eligibility process.

(3) Provisions by the tribe to ensure that individuals who will be responsible for the tribe's duties and responsibilities under this agreement shall be employed under standards equivalent to current standards for a Merit System of Personnel Administration or any standards later prescribed by the Office of Personnel Management under section 208 of the Intergovernmental Personnel Act of 1970, unless an exemption is obtained from the federal government. The tribe shall also provide the Department with information to verify the unemployment standards included under this condition.

(4) Requirements and procedures for allocating to the tribe in a timely manner all federal funds, nonfederal matching funds, and State funds for State programs previously borne by the State. However, requirements and procedures for allocating funds pursuant to this subdivision shall not include any funding the tribe receives directly from federal agencies.

(5) The Department shall, when possible and as allowed by the federal government, adopt funding flexibility for Indian Health Services when such flexibility furthers goals addressing health disparities among American Indians. (1937, c. 135, s. 1; c. 288, ss. 3, 31; 1949, c. 1038, s. 2; 1955, c. 1044, s. 1; 1957, c. 100, s. 1; 1965, c. 1173, s. 1; 1969, c. 546, s. 1; 1973, c. 476, s. 138; 1975, c. 92, s. 4; 1977, 2nd Sess., c. 1219, s. 9; 1979, c. 702, s. 1; 1981, c. 275, s. 1; 1997-443,

ss. 11A.118(a), 11A.122, 12.3; 2004-203, s. 41; 2007-97, s. 3; 2010-31, s. 10.19A(b); 2014-100, s. 12C.3(c); 2015-241, s. 12C.10(a); 2017-57, s. 11H.22(a); 2022-74, s. 9D.15(z).)

**§ 108A-25.1:** Repealed by Session Laws 2001-424, s. 21.52.

**§ 108A-25.1A. Responsibility for errors.**

(a) A county department of social services shall be financially responsible for the erroneous issuance of Medicaid benefits and Medicaid claims payments resulting when the county department of social services takes any action that requires payment of Medicaid claims for an ineligible individual, for ineligible dates, or in an amount that includes a recipient's liability and for which the State cannot claim federal participation.

(b) 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 State.

(c) The amounts to be charged back to a county department of social services for erroneous payments of claims shall be the State and federal shares of all erroneous payments, not to exceed the lesser of the amount of actual error or claims payment. (2017-57, s. 11H.22(f).)

**§ 108A-25.2. Exemption from limitations for individuals convicted of certain drug-related felonies.**

Individuals convicted of Class H or I controlled substance felony offenses in this State shall be eligible to participate in the Work First Program and the food and nutrition services program:

(1) Six months after release from custody if no additional controlled substance felony offense is committed during that period and successful completion of or continuous active participation in a required substance abuse treatment program determined appropriate by the area mental health authority; or

(2) If not committed to custody, six months after the date of conviction if no additional controlled substance felony offense is committed during that period and successful completion of or continuous active participation in a required substance abuse treatment program determined appropriate by the area mental health authority.

A county department of social services shall require individuals who are eligible for Work First Program assistance and electronic food and nutrition benefits pursuant to this section to undergo substance abuse treatment as a condition for receiving Work First Program or electronic food and nutrition benefits, if funds and programs are available and to the extent allowed by federal law. (1997-443, s. 12.4; 2007-97, s. 4; 2008-187, s. 17.)

**§ 108A-25.3. Garnishment of wages to recoup fraudulent public assistance program payment.**

(a) The following definitions apply in this section:

(1) Disposable income. – The part of the compensation paid or payable for personal services, whether denominated as wages, salary, commission, bonus, or otherwise which remains after the deduction of any amounts required by law to be withheld.

(2) Fraudulent payment. – Any public assistance program payment made because of a recipient's false statement or representation or failure to disclose a material fact which occurs willfully and knowingly and with intent to deceive.

(3) Garnishee. – The person, firm, association, or corporation owing compensation for personal services, whether denominated as wages, salary, commission, bonus, or otherwise.

(4) Public assistance program. – Any means-tested benefit program administered or supervised by a county department of social services or the Department of Health and Human Services which is funded in whole or in part by federal, State, or county resources.

(b) In any case in which a recipient or former recipient of a public assistance program, who while a recipient, obtained or benefited from a fraudulent payment, a judge of the district court in the county where the recipient or former recipient resides or is found, or in the county where the payment was made, may enter an order of garnishment to recoup a fraudulent payment after 10 days following the entry of a judgment for a sum certain for fraudulent payments pursuant to a petition filed in the action in accordance with subsection (c) of this section. Not more than twenty percent (20%) of the recipient's or former recipient's monthly disposable income may be garnished to recoup payment in cases of fraudulent payment. The order of garnishment shall be subject to all federal and State laws or regulations that may apply to recoupment of fraudulent payments. Garnishment shall not be a remedy under this section when the recipient or former recipient is required to pay restitution for fraudulent public assistance payments pursuant to a criminal court order.

(c) A county department of social services or the Department of Health and Human Services may petition the court for an order of garnishment to recoup a fraudulent public assistance program payment. Garnishment shall be a remedy to recoup payment only after all administrative remedies are exhausted unsuccessfully. The petition shall be verified and provide the court with facts and circumstances of the fraudulent payment to or on behalf of the recipient or former recipient, the name and address of the garnishee, the recipient's or former recipient's monthly disposable income (which may be based on information and belief), and the amount sought to be garnished from the recipient's or former recipient's disposable income. The petition shall be served on both the recipient or former recipient and the garnishee in accordance with the provisions for service of process set forth in G.S. 1A-1, Rule 4. The time period for answering or otherwise responding to process issued pursuant to this section shall be in accordance with the time periods set forth in G.S. 1A-1, Rule 12.

(d) Upon a hearing held pursuant to this section, the court may enter an order of garnishment. Provided, the court may not enter an order of garnishment if the court finds that the order jeopardizes the recipient's or former recipient's ability to become or remain financially self-sufficient and will result in the likelihood of an increased or recurring dependency on public assistance or an inability to secure basic necessities including, but not limited to, housing, food, health care, and utility costs. If an order of garnishment is entered, a copy of the same shall be served on both the recipient or the former recipient and the garnishee either personally or by certified or registered mail, return receipt requested. The order shall set forth sufficient findings of facts to support the action by the court and the amount to be garnished for each pay period. The amount garnished may be increased by an additional one dollar ($1.00) processing fee to be assessed and retained by the garnishee for each payment under the order. The order shall be subject to review for modification and dissolution upon the filing of a motion in the cause.

(e) Upon receipt of the order of garnishment, the garnishee shall transmit without delay to the clerk of superior court the amount ordered by the court to be garnished. These funds shall be disbursed to the county department of social services to recoup fraudulent payments subject to the order of garnishment entered pursuant to this section.

(f) A garnishee who violates the terms of an order of garnishment shall be subject to punishment for contempt.

(g) The Social Services Commission shall adopt rules to implement this section. The rules shall ensure that a petition for an order of garnishment sought pursuant to this section is consistent with all federal and State laws and regulations. (1997-443, s. 11A.122; 1997-497, s. 1.)

**§ 108A-25.4. Use of payments under the Low-Income Energy Assistance Program and Crisis Intervention Program.**

(a) The Low-Income Energy Assistance Program Plan developed by the Department of Health and Human Services (Department) and submitted to the U.S. Department of Health and Human Services shall focus the annual energy assistance payments on the elderly population age 60 and above with income up to one hundred fifty percent (150%) of the federal poverty level and disabled persons receiving services through the Division of Aging and Adult Services. The energy assistance payment shall be paid directly to the service provider by the county department of social services. The Plan for Crisis Intervention Program (CIP) shall provide assistance for vulnerable populations who meet income eligibility criteria established by the Department. The CIP payment shall be paid directly to the service provider by the county department of social services and shall not exceed one thousand dollars ($1,000) per household in a fiscal year.

(b) The Department shall submit the Plan for each program to the U.S. Department of Health and Human Services no later than September 1 of each year and implement the Plan no later than October 1 of each year. (2011-145, s. 10.56(a); 2022-74, s. 9I.1.)

**§ 108A-26. Certain financial assistance and in-kind goods not considered in determining assistance paid under Chapters 108A and 111.**

Financial assistance and in-kind goods or services received from a governmental agency, or from a civic or charitable organization, shall not be considered in determining the amount of assistance to be paid any person under Chapters 108A and 111 of the General Statutes provided that such financial assistance and in-kind goods and services are incorporated in the rehabilitation plan of such person being assisted by the Division of Vocational Rehabilitation Services or the Division of Services for the Blind of the Department of Health and Human Services, except where such goods and services are required to be considered by federal law or regulations. (1973, c. 716; 1981, c. 275, s. 1; 1997-443, s. 11A.118(a).)

**§ 108A-26.1. Information sharing of outstanding arrest warrant of applicant for or recipient of program assistance.**

(a) A county department of social services shall notify an applicant for program assistance under Part 2 or Part 5 of this Article that release of confidential information from the applicant's records may not be protected if there exists an outstanding warrant for arrest against the applicant. A county department of social services shall notify a recipient under a program of public assistance under Part 2 or Part 5 of this Article at the time of renewal of the recipient's application for such program assistance that release of confidential information from the recipient's records may not be protected if there exists an outstanding warrant for arrest against the recipient.

(b) Notwithstanding G.S. 108A-80, and to the extent otherwise allowed by federal and State law, a county department of social services shall ensure that the criminal history of an applicant, or of a recipient at the time of benefits renewal, is checked in a manner and to the extent necessary to verify whether an applicant for or recipient of program assistance under Part 2 or Part 5 of this Article is (i) fleeing to avoid prosecution, custody, or confinement after conviction under the laws of the place from which the individual flees, for a crime or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees, or (ii) violating a condition of probation or parole imposed under federal or State law.

A criminal history check utilizing currently accessible databases shall be conducted by the county department of social services, subject to G.S. 114-19.34 and to the extent permitted by allocated county and State resources.

Nothing in this section requires fingerprints to be taken of every applicant for or recipient of a program of public assistance.

Counties are not required to allocate funds to comply with this section but are authorized to make such allocations on a voluntary basis.

(c) Nothing in this section shall be construed to authorize the disclosure of any information otherwise protected by State or federal law or regulation.

(d) This section applies to applicants for or recipients of program assistance under Part 2 or Part 5 of this Article only.

(e) The Social Services Commission shall adopt any rules necessary to implement this section, including rules addressing the sharing of confidential information between county departments of social services and law enforcement agencies.

(f) The Secretary of the Department of Health and Human Services shall promote cooperation among State and local agencies to perform the functions described in this section. The Department of Health and Human Services shall cooperate and collaborate with the Office of the State Controller, the Administrative Office of the Courts, the Department of Justice, the State Bureau of Investigation, and the Department of Public Safety to develop protocols to implement this section.

(g) Annually on April 1, each county department of social services shall report to the Department of Health and Human Services on the number of individuals who are denied benefits under this section during the preceding calendar year.

(h) Annually on May 1, the Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Health and Human Services of the General Assembly on the number of individuals who are denied assistance under this section. The report shall include a breakdown by county. (2013-417, s. 1.)

**§ 108A-26.2. Fleeing felon or parole or probation violator; eligibility for program assistance; federal approval; review by department.**

(a) Subject to subsection (b) of this section, a department of social services shall not grant public assistance under Part 2 or Part 5 of Article 2 of Chapter 108A of the General Statutes if the department receives information described in G.S. 108A-26.1 that the applicant for or recipient of program assistance is subject to arrest under an outstanding warrant arising from a charge of violating conditions of parole or probation or from a felony charge against that applicant or recipient in any jurisdiction. This section does not affect the eligibility for assistance of other members of the applicant's or recipient's household. An applicant or recipient described in this section is eligible for program assistance if all other eligibility criteria of the law are met when the

applicant or recipient is no longer subject to arrest under an outstanding warrant as described in this section.

(b) If federal approval is required in order to prevent the loss of federal reimbursement as a result of the application of this section to an applicant for or recipient of program assistance, the Department of Health and Human Services shall promptly take any action necessary to obtain federal approval. (2013-417, s. 2.)

**§ 108A-26.5. NC FAST caseworker training and certification program.**

The Department of Health and Human Services (Department) shall design and implement a training and certification program for caseworkers utilizing North Carolina Families Accessing Services Through Technology (NC FAST). The training and certification program shall be available on a statewide basis, and the Department shall provide training to caseworkers at county departments of social services at a location within reasonable travel distance from the county departments of social services multiples times per year. No later than 18 months after the Department has implemented the training and certification program, the Department shall require all caseworkers inputting data or making determinations for eligibility for State programs through NC FAST to be certified. A certification may last no longer than three years before an individual is required to be recertified. The Department may adopt and amend rules to implement this training and certification program. (2017-57, s. 11H.22(g).)

Part 2. Work First Program.

**§ 108A-27. (See editor's note) Authorization and description of Work First Program; Work First Program changes; designation of Electing and Standard Program Counties.**

(a) The Department shall establish, supervise and monitor the Work First Program. The purpose of the Work First Program is to provide eligible families with short-term assistance to facilitate their movement to self-sufficiency through gainful employment, not the mere reduction of the welfare rolls. The Department shall ensure that the Work First Program focuses on this purpose of self-sufficiency. The ultimate goal of the Work First Program is the gradual elimination of generational poverty, and the Department shall ensure that all evaluations of the Work First Program, whether performed at the State or the county level, maintain this purpose and this goal of the Work First Program and effect an ongoing determination of whether the Work First Program is successful in facilitating families to move to self-sufficiency and in gradually eliminating generational poverty.

(b) The Work First Program in all counties shall include program administration and three categories of assistance to participants:

(1) Work First Diversion Assistance;

(2) Work First Family Assistance; and

(3) Work First Services.

(c) The Department may change the Work First Program when required to comply with federal law. Any changes in federal law that necessitate a change in the Work First Program shall be effected by temporary rule until the next State Plan is approved by the General Assembly. Any change effective by the Department to comply with federal law shall be reported to the Senate Appropriations Committee on Health and Human Services and the House of Representatives Appropriations Subcommittee on Health and Human Services and included in the State Plan submitted during the next session of the General Assembly following the change.

(d) The Department shall allow counties maximum flexibility in the Work First Program while ensuring that the counties comply with federal and State laws and regulations. Subject to any limitations imposed by law, the Department shall allow counties to request to be designated as either Electing Counties or Standard Program Counties in the Work First Program.

(e) All counties shall notify the Department in writing as to whether they desire to be designated as either Electing or Standard Program. A county shall submit in its notification to the Department documentation demonstrating that three-fifths of its county commissioners support its desired designation. Upon receipt of the notification from the county, the Department shall send to the county confirmation of the county's planning designation. A county that desires to be redesignated shall submit a request in writing to the Department at least six months prior to the effective date of the next State Plan. In its request for redesignation, the county shall submit documentation demonstrating that three-fifths of its county commissioners support the redesignation. Upon receipt of the notification from the county, the Department shall send to the county confirmation of the county's planning redesignation. A county's redesignation shall become effective on the effective date of the next State Plan following the redesignation. A county's designation or redesignation shall not be effected except as provided in this Article.

(f) The board of county commissioners in an Electing County shall be responsible for development, administration, and implementation of the Work First Program in that county.

(g) The county department of social services in a Standard Program County shall be responsible for administering and implementing the Standard Work First Program in that county.

(h) The Department and Electing Counties, in developing their respective plans, may distinguish among potential groups of recipients on whatever basis necessary to enhance program purposes and to maximize federal revenues, so long as the rights, including the constitutional rights of equal protection and due process, of individuals are protected. The Department and Electing Counties shall provide Work First Program assistance to qualified immigrants on the same basis as citizens to the extent permitted by federal law. (1981, c. 275, s. 1; 1997-443, s. 12.5; 1998-212, s. 12.27A(a1); 2001-424, s. 21.13(e); 2009-489, s. 2.)

Part 2. Work First Program.

**§ 108A-27.01. Income eligibility and payment level for Work First Family Assistance.**

The maximum net family annual income eligibility standards for Work First Family Assistance are as provided in the table below. The payment level for Work First Family Assistance shall be fifty percent (50%) of the standard of need.

| Family Size | Income Level |
|---|---|
| 1 | $ 4,344 |
| 2 | 5,664 |
| 3 | 6,528 |
| 4 | 7,128 |
| 5 | 7,776 |
| 6 | 8,376 |
| 7 | 8,952 |
| 8 | 9,256 |

(2013-360, s. 12C.8; 2014-100, s. 12C.2.)

**§ 108A-27.1. Time limitations on assistance.**

(a) Under the Standard Work First Program, unless an extension or an exemption is provided pursuant to the provisions of the Part or the State Plan, any cash assistance provided to a person or family in the employment program shall only be provided for a cumulative total of 24 months. After having received cash assistance for 24 months, the person or the family may reapply for cash assistance, but not until after 36 months from the last month the person or the family received cash assistance. This subsection shall not apply to child-only cases.

(b) Electing Counties may set any time limitations on assistance it finds appropriate, so long as the time limitations do not conflict with or exceed any federal time limitations. (1997-443, s. 12.6; 1998-212, s. 12.27A(f).)

**§ 108A-27.2. General duties of the Department.**

The Department shall have the following general duties with respect to the Work First Program:

(1) Ensure that the specifications of the general provisions of the State Plan regarding the procedures required when recipients are sanctioned, prescribed in G.S. 108A-27.9(c), are uniformly developed and implemented across the State;

(1a) Provide technical assistance to Electing Counties developing and implementing and to Standard Counties implementing their County Plans, including providing information concerning applicable federal law and regulations and changes to federal law and regulations that affect the permissible use of federal funds and scope of the Work First Program in a county;

(1b) Reserved for future codification purposes.

(1c) Ensure that all families with work eligible parents and parents with children under the age of 12 months receive Work First benefits in the month after compliance with their Mutual Responsibility Agreement. Failure to comply with their Mutual Responsibility Agreement shall result in no Work First Benefits the following month, unless there is good cause.

(2) Describe authorized federal and State work activities. For up to twenty percent (20%) of Work First recipients, authorized State work activities shall include at least part-time enrollment in a postsecondary education program. In Standard Counties, recipients enrolled on at least a part-time basis in a postsecondary education program and maintaining a 2.5 grade point average or its equivalent shall have their two-year time limit suspended for up to three years.

(3) Define requirements for assignment of child support income and compliance with child support activities;

(4) Establish a schedule for Electing Counties to submit their County Plans to ensure that all Electing County Plans are adopted by Electing Counties by February 1 of each odd-numbered year and review and then recommend a State Plan to the General Assembly;

(5) Ensure that the Electing County Plans comply with federal and State laws, rules, and regulations, are consistent with the overall purposes and goals of the Work First Program, and maximize federal receipts for the Work First Program;

(6) Prepare the State Plan in accordance with G.S. 108A-27.9 and federal laws and regulations and submit it to the Budget Director for approval;

(7) Submit the State Plan, as approved by the Budget Director, to the General Assembly for approval;

(8) Repealed by Session Laws 2003-284, s. 10.57, effective July 1, 2003.

(9) Develop and implement a system to monitor and evaluate the impact of the Work First Program on children and families, including the impact of the Work First Program on job retention and advancement, child abuse and neglect, caseloads for child protective services and foster care, school attendance, academic and behavioral performance, and other measures of the economic security and health of children and families. The system should be developed to allow monitoring and evaluation of impact based on both aggregated and disaggregated data. State and county agencies shall cooperate in providing information needed to conduct these evaluations, sharing data and information except where prohibited specifically by federal law or regulation;

(10) Monitor the performance of Electing Counties relative to their respective Plans and the overall goals of the Work First Program. Monitor Standard Counties relative to the State Plan and the overall goals of the Standard Work First Program;

(11) Repealed by Session Laws 2003-284, s. 10.57, effective July 1, 2003.

(12) Report to the Senate Appropriations Committee on Health and Human Services and the House of Representatives Appropriations Subcommittee on Health and Human Services the counties which have requested Electing status; provide copies of the proposed Electing County Plans to the Senate Appropriations Committee on Health and Human Services and the House of Representatives Appropriations Subcommittee on Health and Human Services, if requested; and make recommendations to the Senate Appropriations Committee on Health and Human Services and the House of Representatives Appropriations Subcommittee on Health and Human Services on which of the proposed Electing County Plans ensure compliance with federal and State laws, rules, and regulations and are consistent with the overall purposes and goals for the Work First Program; and

(13) Make recommendations to the General Assembly for approval of counties to become Electing Counties which represent, in aggregate, no more than fifteen and one-half percent (15.5%) of the total Work First caseload at September 1 of each year and, for each county submitting a plan, the reasons individual counties were or were not recommended.

(14) Review the county Work First Program of each Electing County and recommend whether the county should continue to be designated an Electing County or whether it should be redesignated as a standard county. In conducting its review and making its recommendation, the Department shall:

a. Examine and consider the results of the Department's monitoring and evaluation of the impact of the Electing County's Work First Program as required under subdivision (9) of this section;

b. Determine whether the Electing County's Work First Program's unique design requires implementation by an Electing County or whether the Work First Program could be implemented by a county designated as a standard county;

c. Determine whether the Electing County's Work First Program and policies are unique and innovative in meeting the purpose of the Work First Program as stated under G.S. 108A-27, and State and federal laws, rules, and regulations, as compared to other standard and Electing County Work First programs.

The Department shall make its recommendation and the reasons therefor to the Senate Appropriations Committee on Health and Human Services and the House of Representatives Appropriations Subcommittee on Health and Human Services not later than three months prior to submitting the State Plan to the Commission for review as required under G.S. 108A-27.9(a). (1997-443, s. 12.6; 1998-212, s. 12.27A(g); 1999-237, s. 7.10(b); 1999-359, ss. 1.2(a), 2(a), (b), 6; 2001-424, s. 21.13(b), (e); 2003-284, s. 10.57; 2009-489, s. 3.)

**§ 108A-27.3. Electing Counties – Duties of county boards of commissioners.**

(a) The duties of the county boards of commissioners in Electing Counties under the Work First Program are as follows:

(1) Establish county outcome and performance goals based on county economic, educational, and employment factors and adopt criteria for determining the progress of the county in moving persons and families to self-sufficiency;

(2) Establish eligibility criteria for recipients except for those criteria related to sanctioning procedures mandated across the State pursuant to G.S. 108A-27.9(c);

(3) Prescribe the method of calculating benefits for recipients;

(4) Repealed by Session Laws 2009-489, s. 4, effective August 26, 2009.

(5) If made a part of the county's Work First Program, develop and enter into Mutual Responsibility Agreements with Work First Program recipients and ensure that the services and resources that are needed to assist participants to comply with the obligations under their Mutual Responsibility Agreements are available;

(6) Ensure that participants engage in the minimum hours of work activities required by Title IV-A;

(7) Consider providing community service work for any recipient who cannot find employment;

(8) Authorize payments of Work First Diversion Assistance and Work First Family Assistance to recipients having MRAs;

(9) Monitor compliance with Mutual Responsibility Agreements and enforce the agreement provisions;

(10) Repealed by Session Laws 2009-489, s. 4, effective August 26, 2009.

(10a) Ensure that all Work First cases are reviewed no later than three months prior to expiration of time limitations for receiving cash assistance to:

a. Ensure that time limitations on assistance have been computed correctly.

b. Ensure that the family is informed in writing about public assistance benefits, including child care, Medicaid, and food and nutrition services, for which the family is eligible even while cash assistance is no longer available.

c. Provide for an extension of cash assistance benefits if the family qualifies for an extension.

d. Review family status and assist the family in identifying resources and support the family needs to maintain employment and family stability.

(11) Ensure compliance with applicable State and federal laws, rules, and regulations for the Work First Program;

(12) Develop, adopt, and submit to the Department a biennial County Plan;

(13) Repealed by Session Laws 2009-489, s. 4, effective August 26, 2009.

(14) Develop and implement an appeals process for the county's Work First Program that substantially complies with G.S. 108A-79 and comply with the procedures related to sanctioning by the Department for all counties in the State pursuant to G.S. 108A-27.2 and prescribed as general provisions in the State Plan pursuant to G.S. 108A-27.9(c)(1).

(b) The county board of commissioners shall not delegate the responsibilities described in subdivisions (a)(1), (a)(11), and (a)(12) of this section but may delegate other duties to public or private entities. Notwithstanding any delegation of duty, the county board of commissioners shall remain accountable for its duties under the Work First Program.

(c) The county board of commissioners shall appoint a committee of individuals to identify the needs of the population to be served and to review and assist in developing the County Plan to respond to the needs. The committee membership shall include, but is not limited to, representatives of the county board of social services, the board of the area mental health authority, the local public health board, the local school systems, the business community, the board of county commissioners and community-based organizations representative of the population to be served.

(d) The county board of commissioners shall review and approve the County Plan for submission to the Department. (1997-443, s. 12.6; 1998-212, s. 12.27A(h); 1999-359, s. 5(a); 2007-97, s. 5; 2009-489, s. 4.)

**§ 108A-27.4. Electing Counties – County Plan.**

(a) Each Electing County shall submit to the Department, according to the schedule established by the Department and in compliance with all federal and State laws, rules, and regulations, a biennial County Plan.

(b) An Electing County's County Plan shall have at least the following five parts:

(1) Part I. Conditions Within the County;

(2) Part II. Outcomes and Goals for the County;

(3) Part III. Plans to Achieve and Measure the Outcomes and Goals;

(4) Part IV. Administration; and

(5) Part V. Funding Requirements.

(c) Funding requirements shall, at least, identify the amount of a county block grant for Work First Diversion Assistance, a county block grant for Work First Family Assistance, a county block grant for Work First Services, and the county's maintenance of effort contribution. A county may establish a reserve.

(d) Repealed by Session Laws 2009-489, s. 5, effective August 26, 2009.

(e) Each county shall include in its County Plan the following:

(1) Repealed by Session Laws 2009-489, s. 5, effective August 26, 2009.

(2) A description of the county's plans for serving families who need child care, transportation, substance abuse services, and employment support based on the needs of the community and the availability of services and funding;
(3) Repealed by Session Laws 2009-489, s. 5, effective August 26, 2009.
(4) A description of the county's eligibility criteria, benefit calculation, and any other policies adopted by the county relating to eligibility, terms, and conditions for receiving Work First Program assistance, including sanctions, asset and income requirements, time limits and extensions, rewards, exemptions, and exceptions to requirements. If an Electing County Plan proposes to change eligibility requirements, benefits levels, or reduce maintenance of effort, the county shall describe the reasons for these changes and how the county intends to utilize the maintenance of effort savings;
(5) A description of how the county plans to utilize public and private resources to assist in moving persons and families to self-sufficiency; and
(6) Any request to the Department for waivers to rules or any proposals for statutory changes to remove any impediments to implementation of the County's Plan.
(7) The process by which the county will review all Work First caseloads no later than three months prior to expiration of time limitations for receiving cash assistance to:
    a. Ensure that time limitations on assistance have been computed correctly.
    b. Ensure that the family is informed in writing about public assistance benefits, including child care, Medicaid, and food and nutrition services, for which the family is eligible even while cash assistance is no longer available.
    c. Provide for an extension of cash assistance benefits if the family qualifies for an extension.
    d. Review family status and assist the family in identifying resources and support the family needs to maintain employment and family stability.

(f) Each county shall provide to the general public an opportunity to review and comment upon its County Plan prior to its submission to the Department.

(g) A county may modify its County Plan once each biennium but not at any other time unless the county notifies the Department of the proposed modification and the Department determines that the proposed modification is consistent with State and federal law and the goals for the Work First Program.

(h) Electing Counties shall have an emergency assistance program for Work First eligible families, as defined in the electing county plan. Counties may establish income eligibility for emergency assistance at or below two hundred percent (200%) of the federal poverty level. (1997-443, s. 12.6; 1999-359, s. 5(b), (c); 2007-97, s. 6; 2007-484, s. 38; 2009-489, s. 5.)

**§ 108A-27.5. Electing Counties – Duties of the Department.**

In addition to the general duties prescribed in G.S. 108A-27.3, the Department shall have the following duties with respect to establishing, supervising, and monitoring the Work First Program in Electing Counties while allowing Electing Counties maximum flexibility in designing and implementing County Plans:

(1) Repealed by Session Laws 2009-489, s. 6, effective August 26, 2009.
(2) At the request of the counties, provide assistance to counties in their activities with private sector individuals and organizations relative to County Plans; and
(3) Establish the baseline for the State maintenance of effort. (1997-443, s. 12.6; 2009-489, s. 6.)

**§ 108A-27.6. Standard Program Counties – Duties of county departments of social services and county boards of commissioners.**

(a) Except as otherwise provided in this Article, the Standard Work First Program shall be administered by the county departments of social services. The county departments of social services in Standard Program Counties shall:

(1) In consultation with the Department and the county board of commissioners, establish outcome and performance measures for all Standard Program Counties. There exist two goals for the Work First Program: to meet or exceed the federal Work Participation Rate of fifty percent (50%) for all Work Eligible families and ninety percent (90%) for all two-parent families;
(2) Determine eligibility of persons and families for the Work First Program;
(3) Enter into Mutual Responsibility Agreements with participants if required under the State Plan and ensure that the services and resources that are needed to assist participants to comply with their obligations under their Mutual Responsibility Agreements are available;
(4) Comply with State and federal law relating to Work First and Title IV-A;
(5) Repealed by Session Laws 2009-489, s. 7, effective August 26, 2009.
(6) Ensure that participants engage in the minimum hours of work activities required by the State Plan and Title IV-A;
(7) Ensure that the components of the Work First Program are funded solely from authorized sources and that federal TANF funds are used only for purposes and programs authorized by federal and State law; and
(8),(9) Repealed by Session Laws 2009-489, s. 7, effective August 26, 2009.
(10) Ensure that all Work First cases are reviewed no later than three months prior to expiration of time limitations for receiving cash assistance to:
    a. Ensure that time limitations on assistance have been computed correctly.
    b. Ensure that the family is informed about public assistance benefits, including child care, Medicaid, and food and nutrition services, for which the family is eligible even while cash assistance is no longer available.
    c. Provide for an extension of cash assistance benefits if the family qualifies for an extension.
    d. Review family status and assist the family in identifying resources and support the family needs to maintain employment and family stability.

(b) In consultation with the Department, a county department of social services may delegate any of its duties under this Article to another public agency or private contractor. Prior to delegating any duty, a county department of social services shall submit its proposed delegation to the Department as the Department may provide. Notwithstanding any delegation of duty, a county department of social services shall remain accountable for its duties under the Work First Program.

(c),(d) Repealed by Session Laws 2009-489, s. 7, effective August 26, 2009. (1997-443, s. 12.6; 1999-359, s. 5(e); 2007-97, s. 7; 2009-489, s. 7.)

**§ 108A-27.7. Standard Program County Plan.**

Standard counties shall have an emergency assistance program for Work First eligible families, as defined in the standard county plan. Counties may establish income eligibility for emergency assistance at or below two hundred percent (200%) of the federal poverty level. (1997-443, s. 12.6; 1999-359, s. 5(d); 2009-489, s. 8.)

**§ 108A-27.8. Standard Program Counties – Duties of Department.**

(a) The Department shall establish, develop, supervise, and monitor the Standard Work First Program. In addition to its general duties prescribed in G.S. 108A-27.2, the Department shall have the following duties with respect to the Standard Work First Program and the Standard Program Counties:

(1) Repealed by Session Laws 2009-489, s. 9, effective August 26, 2009.
(2) Advise and assist the Social Services Commission in adopting rules necessary to implement the provisions of this Article;
(3) Supervise disbursement of county block grants to the Standard Program Counties for Work First Services;
(4) Make payments of Work First Family Assistance and Work First Diversion Assistance; and
(5), (6) Repealed by Session Laws 2009-489, s. 9, effective August 26, 2009.
(7) Develop a Mutual Responsibility Agreement for use by Standard Program Counties.

(b) The Secretary, in consultation with the Office of State Budget and Management, may adopt temporary rules when necessary to:

(1) Implement provisions of the State Plan;
(2) Maximize federal revenues to prevent the loss of federal funds;
(3) Enhance the ability of the Department to prevent fraud and abuse in the Work First Program; and
(4) Modify the provisions in the State Plan as necessary to meet changed circumstances after approval of the State Plan.

(c) The Social Services Commission may adopt rules in accordance with G.S. 143B-153 when necessary to implement this Article and subject to delegation by the Secretary of any rule-making authority to implement the provisions of the State Plan. (1997-443, s. 12.6; 2000-140, s. 93.1(a); 2001-424, s. 12.2(b); 2009-489, s. 9.)

**§ 108A-27.9. State Plan.**

(a) The Department shall prepare and submit to the Director of the Budget a biennial State Plan that proposes the goals and requirements for the State and the terms of the Work First Program for each fiscal year. Prior to submitting a State Plan to the General Assembly, the Department shall:

(1) Consult with local government and private sector organizations regarding the design of the State Plan and allow 45 days to receive comments from those organizations; and

(2) Upon complying with subdivision (1) of this subsection, submit the State Plan to the Senate Appropriations Committee on Health and Human Services and the House of Representatives Appropriations Subcommittee on Health and Human Services for review.

(b) The State Plan shall consist of generally applicable provisions and two separate sections, one proposing the terms of the Work First Program in Electing Counties, and the other proposing the terms for the Standard Work First Program.

(c) The State Plan shall include the following generally applicable provisions:

(1) Provisions to ensure that recipients who are sanctioned are provided a clear explanation of the sanction and that all recipients, including those under sanction or termination for rules infractions, are fully informed of their right to legal counsel and any other representatives they choose at their own cost;

(1a) Provisions to ensure that no Work First Program recipients, required to participate in work activities, shall be employed or assigned when:

a. Any regular employee is on layoff from the same or substantially equivalent job;

b. An employer terminates any regular employee or otherwise causes an involuntary reduction in the employer's workforce in order to hire Work First recipients; or

c. An employer otherwise causes the displacement of any currently employed worker or positions, including partial displacements such as reductions in hours of nonovertime work, wages, or employment benefits, in order to hire Work First recipients;

(1b) Reserved for future codification purposes.

(1c) Provisions to ensure that all work eligible parents and all parents with a child under 12 months of age are subject to pay for performance requirements. Pay for performance requirements means that the family will receive Work First benefits in the month following a month that they comply with their Mutual Responsibility Agreement. Failure to comply with the Mutual Responsibility Agreement without good cause will result in no Work First benefits in the following month.

(2) Provisions to ensure the establishment and maintenance of grievance procedures to resolve complaints by regular employees who allege that the employment or assignment of a Work First Program recipient is in violation of subdivision (1a) of this subsection, and grievance procedures to resolve complaints by Work First Participants made pursuant to subdivision (3) of this subsection;

(3) Provisions to ensure that Work First Program participants, required to participate in work activities, shall be subject to and have the Work First Program employees in similarly situated work activities, including, but not limited to, wage and hour laws, health and safety standards, and nondiscrimination laws, provided that nothing in this subdivision shall be construed to prohibit Work First Program participants from receiving additional State or county services designed to assist Work First Program participants achieve job stability and self-sufficiency;

(4) A description of eligible federal and State work activities. For up to twenty percent (20%) of Work First recipients, authorized State work activities shall include at least part-time enrollment in a postsecondary education program. In Standard Counties, recipients enrolled on at least a part-time basis in a postsecondary education program and maintaining a 2.5 grade point average or its equivalent shall have their two-year time limit suspended for up to three years.

(5) Requirements for assignment of child support income and compliance with child support activities;

(6) Incentives for high-performing counties, contingency plans for counties unable to meet financial commitments during the term of the State Plan, and sanctions against counties failing to meet performance expectations, including allocation of any federal penalties that may be assessed against the State as a result of a county's failure to perform; and

(7) Anything else required by federal or State law, rule, or regulation to be included in the State Plan.

(d) The section of the State Plan proposing the terms of the Work First Program in Electing Counties shall be based upon the aggregate of the Electing County Plans and shall include federal eligibility requirements and a description of the eligibility requirements and benefit calculation in each Electing County.

The Department may modify the section in the State Plan regarding Electing Counties once a biennium or except as necessary to reflect any modifications made by an Electing County. Any changes to the section of the State Plan regarding Electing Counties shall be reported to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division within one month following the changes.

(e) The section of the State Plan describing the Standard Work First Program shall include:

(1) Benefit levels, limitations, and payments and the method for calculating benefit levels and payments;

(2) Eligibility criteria, including asset and income standards;

(3) Any exceptions or exemptions proposed to work requirements;

(4) Provisions for when extensions may be granted to a person or family who reaches the time limit for receipt of benefits;

(5) Provisions for exceptions and exemptions to criteria, time limits, and standards;

(6) Provisions for sanctions for recipient failure to comply with program requirements; and

(7) through (10) Repealed by Session Laws 2009-489, s. 7, effective August 26, 2009.

(11) A description of the Department's consultation with local governments and private sector organizations and a summary of any comments received during the 45-day public comment period.

(f) In addition to those items required to be included pursuant to subsection (e) of this section, the State Plan may include proposals to establish the following as part of the Standard Work First Program:

(1) Demonstration projects in one or more counties to assess the value of any proposed changes in State policy or to test ways to improve programs; and

(2) Requirement that recipients shall be required to enter into and comply with Mutual Responsibility Agreements as a condition of receiving benefits. If provided for in the State Plan, the terms and conditions of Mutual Responsibility Agreements shall be consistent with program purposes, federal law, and availability of funds.

(g) The State Plan may provide for automatic Medicaid eligibility for all Work First Program recipients.

(h) The State Plan may provide that in cases where benefits are paid only for a child, the case is considered a family case. (1997-443, s. 12.6; 1997-456, s. 55.10; 1998-212, s. 12.27A(b), (b1); 1999-359, ss. 1.2(b), 2(c); 2001-424, s. 21.13(c), (e); 2007-323, s. 10.35A(a); 2009-489, s. 10.)

**§ 108A-27.10. Duties of the Director of the Budget/Governor.**

(a) The Director of the Budget shall, by May 15 of each odd-numbered year, approve and recommend adoption by the General Assembly of the State Plan.

(b) At the beginning of every fiscal year, the Director of the Budget shall report to the General Assembly the number of permanent State employees who have been Work First Program recipients during the previous calendar year.

(c) After the State Plan has become law, the Governor shall sign it and cause it to be submitted to federal officials in accordance with federal law. (1997-443, s. 12.6; 2007-323, s. 10.35A(b).)

**§ 108A-27.11. Work First Program funding.**

(a) County block grants, except funds for Work First Family Assistance, shall be computed based on the percentage of each county's total AFDC (including AFDC-EA) and JOBS expenditures, except expenditures for cash assistance, to statewide actual expenditures for those programs in fiscal year 1995-96. The resulting percentage shall be applied to the State's total certified budget enacted by the General Assembly for each fiscal year, except for State funds budgeted for State and county demonstration projects authorized by the General Assembly and for Work First Family Assistance payments.

(b) The following shall apply to funding for Standard Program Counties:

(1) The Department shall make payments of Work First Family Assistance and Work First Diversion Assistance subject to the availability of federal, State, and county funds.

(2) The Department shall reimburse counties for county expenditures under the Work First Program subject to the availability of federal, State, and county funds.

(c) Each Electing County's allocation for Work First Family Assistance shall be computed based on the percentage of each Electing County's total expenditures for cash assistance to statewide actual expenditures for cash assistance in 1995-96. The resulting percentage shall be applied to the federal TANF block grant funds appropriated for cash assistance by the General Assembly each fiscal year. The Department shall transmit the federal funds contained in the county block grants to Electing Counties as soon as practicable after they become available to the State and in accordance with federal cash management laws and regulations. (1997-443, s. 12.6; 1998-212, s. 12.27A(i); 1999-359, s. 3; 2002-126, s. 10.37; 2003-284, s. 10.50.)

**§ 108A-27.12. Maintenance of effort.**

(a) The Department shall define in the State Plan the services that can be provided with TANF federal funds and with State and county maintenance of effort funds. The Department shall work with counties to allow flexibility in the spending of county, State, and federal funds so as to maximize the use of resources while assuring that federal maintenance of effort requirements are met.

(b) Counties that fail to meet maintenance of effort requirements and that fail to meet the performance indicators for reducing maintenance of effort shall submit a corrective action plan to the Department and shall be subject to G.S. 108A-27.14. The Department may reduce block grant allocations to counties that fail to meet maintenance of effort requirements and performance indicators or may use some of the county's block grant allocation to secure needed services for clients in that county. If a county fails to comply with maintenance of effort requirements, the Director of the Budget may also withhold State funds appropriated to the county pursuant to G.S. 108A-93.

(c) The Department shall maintain the State's maintenance of effort at one hundred percent (100%) of the State certified budget enacted by the General Assembly for programs under this Part during fiscal year 1996-97. At no time shall the Department reduce or reallocate State funds previously obligated or appropriated for Work First or child welfare services.

(d) Each standard county shall maintain funding in Work First, child welfare, and related activities as defined by the Department at one hundred percent (100%) of the county funds budgeted in State Fiscal Year 1996-97 for AFDC Administration, JOBS employment and training, and AFDC Emergency Assistance (cash and services). A county may request to reduce its block grant and maintenance of effort if that county can demonstrate that it is meeting all the needs of its clients, as defined by the Department's performance indicators, without spending all of the block grant funds. The needs of clients include child protection, employment services, and related supportive services such as child care. The Department may reallocate any State or federal funds released from a county that reduced its maintenance of effort or from counties not spending their block grants. Funds reallocated to counties will require county match.

(e) During the first year a county operates as an Electing County, the county's maintenance of effort shall be no less than ninety percent (90%) of the amount the county budgeted for programs under this Part during fiscal year 1996-97. If during the first year of operation as Electing the Electing County achieves one hundred percent (100%) of its goals as set forth in its Electing County Plan, then the Electing County may reduce its maintenance of effort to eighty percent (80%) of the amount the county budgeted for programs under this Part during fiscal year 1996-97 for the second year of the Electing County's operation and for all years thereafter that the county maintains Electing Status.

(f) The Department may realign funds if the realignment will assure that maintenance of effort requirements are met while maximizing federal revenues.

(g) The Department of Health and Human Services shall report quarterly on the extent to which the State and counties are meeting federal maintenance of effort requirements under Temporary Assistance of Needy Families and on any realignment of funds. The Department and the counties shall work together to maximize full achievement of the State and county maintenance of effort. The Department shall make its report to members of the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Joint Legislative Public Assistance Committee, and to the Fiscal Research Division. (1997-443, s. 12.6; 1998-212, s. 12.27A(j); 1999-359, s. 4(a), (c).)

**§ 108A-27.13. Performance standards.**

(a) The Department, in consultation with the county department of social services and county board of commissioners, shall establish outcome and performance measures for all counties, both Electing and Standard. There exist two goals for the Work First Program: to meet or exceed the federal Work Participation rate of fifty percent (50%) for all Work Eligible families and ninety percent (90%) for all two-parent families. The two goals apply to both Standard and Electing Counties. The Department shall establish monitoring mechanisms and reporting requirements to assess progress toward the goals. The well-being of children and economic factors and conditions within the counties, including the increased numbers of persons employed and increased numbers of hours worked by and wages earned by recipients, shall be considered by the Department.

(b) Repealed by Session Laws 2009-489, s. 11, effective August 26, 2009.

(c) All adult recipients of Work First Program assistance are expected to achieve full-time employment, subject to applicable exceptions. Adult recipients of Work First Program assistance shall comply with the provisions and requirements in their MRAs. (1997-443, s. 12.6; 2009-489, s. 11.)

**§ 108A-27.14. Corrective action.**

(a) When any county fails to meet acceptable levels of performance, the Department may take one or more of the following actions to assist the county in meeting its Work First goals:

(1) Notify the county of the deficiencies and add additional monitoring and reporting requirements.

(2) Require the county to develop and submit for approval by the Department a corrective action plan.

(b) If any Standard Program County fails to meet acceptable levels of performance for two consecutive years, or fails to comply with a corrective action plan developed pursuant to this section, the Department may assume control of the county's Work First Program, appoint an administrator to administer the county's Work First Program, and exercise the powers assumed to administer the Work First Program either directly or through contract with private or public agencies. County funding shall continue at levels established by the State Plan when the State has assumed control of a county Work First Program. At no time after the State has assumed control of a Work First Program shall a county withdraw funds previously obligated or appropriated to the Work First Program.

(c) If an Electing County fails to achieve its Work First Program goals for two consecutive years, or fails to comply with a corrective action plan developed pursuant to this section, and as a result the federal government imposes a penalty upon the State, then the county shall lose its Electing County status. (1997-443, s. 12.6.)

**§ 108A-27.15. Assistance not an entitlement; appeals.**

(a) Any assistance programs established under this Part, whether administered by the Department or the counties, are not entitlements, and nothing in this Part shall create any property right.

(b) The Standard Work First Program is a program of temporary public assistance for the purpose of an appeal under G.S. 108A-79. (1997-443, s. 12.6.)

**§ 108A-27.16.** Repealed by Session Laws 1999-237, s. 6(h).

**§§ 108A-28, 108A-28.1: Repealed by Session Laws 1997-443, s. 12.14.**

**§ 108A-29. Priority for employment services.**

(a) Repealed by Session Laws 2009-489, s. 12, effective August 26, 2009.

(b) Individuals seeking to apply or reapply for Work First Program assistance and who are not exempt from work requirements shall register with the Division of Employment Security for employment services. The point of registration shall be at an office of the Division in the county in which the individual resides or at another location designated in a Memorandum of Understanding between the Division and the local department of social services.

(c) Individuals who are not otherwise exempt shall present verification of registration for Work First Program assistance. Unless exempt, the individual shall not be approved for Work First Program assistance until verification is received. Child-only cases are exempt from this requirement.

(d) Once an individual has registered as required in subsection (c) of this section and upon verification of the registration by the agency or contractor providing the Work First Program assistance, the individual's eligibility for Work First Program assistance may be evaluated and the application completed. Continued receipt of Work First Program benefits is contingent upon successful participation in employment services in the Mutual Responsibility Agreement, and lack of cooperation and participation in employment services may result in the termination of benefits to the individual.

(e) Repealed by Session Laws 2009-489, s. 12, effective August 26, 2009.

(f) Each county department of social services shall enter into a cooperative agreement with the local Division to operate the Job Search component on behalf of Work First Program registrants. The cooperative agreement shall include a provision for payment to the Division by the county department of social services for the cost of providing those services, not otherwise available to all clients of the Division, described in this subsection as the same are reflected as a component of the County Plan payable from fund allocations in the county block grant. The county department of social services may also enter into a cooperative agreement with the community college system or any other entity to operate the Job Preparedness component. This cooperative agreement shall include a provision for payment to that entity by the county department of social services for the cost of providing those services, not otherwise available to all clients of the Division, described in this subsection as the same are reflected as a component of the County Plan payable from fund allocations in the county block grant.

(g) The Division shall further assist registrants through job search, job placement, or referral to community service, if contracted to do so.

(h) An individual placed in the Job Search component of the Division or other agency providing Job Search services shall look for work and shall accept any suitable employment. If contracted, the Division shall refer individuals to current job openings and shall make job development contacts for individuals. Individuals so referred shall be required to keep a record of their job search activities on a job search record form provided by the Division, and the Division will monitor these activities. A "job search record" means a written list of dates, times, places, addresses, telephone numbers, names, and circumstances of job interviews. The Job Search component shall include at least one weekly contact with the Division. The Division shall adopt rules to accomplish this subsection.

(i) The Division of Employment Security shall notify all employers in the State of the "Exclusive No-Fault" Referral Service available through the Division of Employment Security to employers who hire personnel through Job Service referrals.

(j) All individuals referred to jobs through the Division of Employment Security shall be instructed in the procedures for applying for the Federal Earned Income Credit (FEIC). All individuals referred to jobs through the Division who qualify for the FEIC shall apply for the FEIC by filing a W-5 form with their employers.

(k) The FEIC shall not be counted as income when eligibility is determined for Work First Program assistance, Medicaid, food and nutrition services, public housing, or Supplemental Security Income.

(l) The Division of Employment Security shall work with the Department of Labor to develop a relationship with these private employment agencies to utilize their services and make referrals of individuals registered with the Division of Employment Security.

(m) An individual who has not found a job within 12 weeks of being placed in the Job Search component of the Program may also be placed in the Community Service component at the county's option.

(n) If after evaluation of an individual the Division of Employment Security believes it necessary, the Division or the county department of social services also may refer an individual to a Job Preparedness provider. The local community college should include adult high school equivalency diploma, Adult Basic Education, or Human Resources Development programs that are already in existence as a part of the Job Preparedness component. Additionally, the Division or the county department of social services may refer an individual to a literacy council. Through a Memorandum of Understanding between the Division of Employment Security, the local department of social services, and other contracted entities, a system shall be established to monitor an individual's progress through close communications with the agencies assisting the individual. The Division of Employment Security or Job Preparedness provider shall adopt rules to accomplish this subsection.

(o) The Job Preparedness component of the Program shall last a maximum of 12 weeks unless the recipient is registered and is satisfactorily progressing in a program that requires additional time to complete. Every reasonable effort shall be made to place the recipient in part-time employment or part-time community service if the time required exceeds the 12-week maximum. The county department of social services may contract with service providers to provide the services described in this section and shall monitor the provision of the services by the service providers. Registrants may participate in more than one component at a time.

(p) The Division shall expand its Labor Market Information System. The expansion shall at least include: statistical information on unemployment rates and other labor trends by county; and publications dealing with licensing requirements, economic development, and career projections, and information technology systems which can be used to track participants through the employment and training process.

(q), (r) Repealed by Session Laws 2009-489, s. 12, effective August 26, 2009.

(s) Members of families with dependent children and with aggregate family income at or below the level required for eligibility for Work First Family Assistance, regardless of whether or not they have applied for such assistance, shall be given priority in obtaining employment services including training and community service provided by or through State agencies or counties or with funds which are allocated to the State of North Carolina directly or indirectly through prime sponsors or otherwise for the purpose of employment of unemployed persons. (1961, c. 998; 1963,

c. 1061; 1965, c. 939, s. 2; 1969, c. 546, s. 1; 1971, c. 283; 1973, c. 476, s. 138; 1977, c. 362; 1981, c. 275, s. 1; 1981 (Reg. Sess., 1982), c. 1282, s. 19; 1989 (Reg. Sess., 1990), c. 966, s. 1; 1997-443, s. 12.7(a); 1998-212, s. 12.27A(l), (m); 1999-340, s. 9; 2001-424, s. 21.13(d), (e); 2007-97, s. 8; 2009-489, s. 12; 2011-401, s. 3.12; 2014-115, s. 28(d).)

**§ 108A-29.1. Drug screening and testing for Work First Program applicants and recipients.**

(a) The Department shall require a drug test to screen each applicant for or recipient of Work First Program assistance whom the Department reasonably suspects is engaged in the illegal use of controlled substances. The Department shall provide notice of drug testing to each applicant or recipient. The notice shall advise the applicant or recipient that drug screening, and testing if there is reasonable suspicion that an individual is engaged in the illegal use of controlled substances, will be conducted as a condition of receiving Work First Program assistance, and that the results of the drug tests will remain confidential and will not be released to law enforcement. Dependent children under the age of 18 are exempt from the requirements of this section. The Department shall require the following:

(1) That for two-parent households, both parents comply with the requirements of this section.

(2) That any teen parent who is emancipated pursuant to Article 35 of Chapter 7B of the General Statutes complies with the requirements of this section.

(3) That each applicant or recipient be advised before drug testing that he or she may inform the agent administering the test of any prescription or over-the-counter medication he or she is taking.

(4) That each applicant or recipient being tested signs a written acknowledgement that he or she has received and understood the notice and advice provided under this subsection.

(5) That each applicant or recipient who fails a drug test understands that he or she has the right to take one or more additional tests at his or her own expense.

(6) That each applicant or recipient who fails a drug test be provided with information regarding substance abuse, substance abuse counseling, and substance abuse treatment options, including a list of substance abuse treatment programs that may be available to the individual.

(b) An applicant or recipient who tests positive for controlled substances as a result of a drug test required under this section is ineligible to receive Work First Program assistance for one year from the date of the positive drug test except as provided in subsections (b1) and (b2) of this section. The individual may reapply after one year. However, if the individual has any subsequent positive drug tests, the individual shall be ineligible for benefits for three years from the date of the subsequent positive drug test unless the individual reapplies pursuant to subsection (b1) or (b2) of this section.

(b1) An applicant or recipient deemed ineligible under subsection (b) of this section may reapply for Work First Program assistance after the expiration of 30 days from the date of the positive drug test if the individual can document either the successful completion of or the current satisfactory participation in a substance abuse treatment program offered by a provider under subsection (e) of this section and licensed by the Department. The applicant or recipient who reapplies for Work First Program assistance after successful completion of a substance abuse program shall pass a drug test. The cost of any drug testing and substance abuse program provided under this subsection shall be the responsibility of the individual being tested and receiving

treatment. An applicant or recipient who reapplies for Work First Program assistance pursuant to this subsection may reapply one time only.

(b2) An applicant or recipient deemed ineligible under subsection (b) of this section may reapply for Work First Program assistance after the expiration of 30 days from the date of the positive drug test if a qualified professional in substance abuse or a physician certified by the American Society of Addiction Medicine determines a substance abuse program is not appropriate for the individual and that individual has passed a subsequent drug test. The cost of any drug testing provided under this subsection shall be the responsibility of the individual being tested. An applicant or recipient who reapplies for Work First Program assistance pursuant to this subsection may reapply one time only.

(c) The children of any applicant or current recipient shall remain eligible for benefits, and these benefits shall be paid to a protective payee pursuant to G.S. 108A-38.

(d) The Social Services Commission shall adopt rules pertaining to the testing of applicants and recipients under this section. The Social Services Commission shall adopt rules pertaining to the successful completion of, or the satisfactory participation in, a substance abuse treatment program under subsection (b1) of this section, including rules regarding timely reporting of completion of or participation in the substance abuse treatment programs.

(e) Area mental health authorities organized pursuant to Article 4 of Chapter 122C of the General Statutes shall be responsible for administering the provisions of this section.

(f) Repealed by Session Laws 2013-417, s. 4, as amended by Session Laws 2014-115, s. 66 (c), effective March 1, 2015.

(g) For the purposes of this section, reasonable suspicion that an applicant for, or recipient of, Work First Program assistance is engaged in the illegal use of controlled substances may be established only by utilizing the following methods:

(1) A criminal record check conducted under G.S. 114-19.34 that discloses a conviction, arrest, or outstanding warrant relating to illegal controlled substances within the three years prior to the date the criminal record check is conducted.

(2) A determination by a qualified professional in substance abuse or a physician certified by the American Society of Addiction Medicine that an individual is addicted to illegal controlled substances.

(3) A screening tool relating to the abuse of illegal controlled substances that yields a result indicating that the applicant or recipient may be engaged in the illegal use of controlled substances.

(4) Other screening methods, as determined by the Social Services Commission under subsection (d) of this section.

(h) Child only cases shall be exempt from the requirements of this section. (1997-443, s. 12.8; 2009-489, s. 13; 2013-417, s. 4; 2014-115, s. 66(c).)

**§ 108A-30: Repealed by Session Laws 1997-443, s. 12.14.**

**§ 108A-31. Application for assistance.**

Any person who believes that the person is eligible to receive Work First Program assistance may apply for assistance to the county department of social services in the county in which the person resides, or, in the case of residents of Electing Counties, to the public or private entity

designated by the board of county commissioners. Counties shall record inquiries for and accept applications from all persons requesting to apply for Work First Program assistance. Counties shall process applications in a reasonable and timely manner. (1937, c. 288, ss. 15, 45; 1939, c. 395, s. 1; 1941, c. 232; 1945, c. 615, s. 1; 1947, c. 91, s. 3; 1953, c. 675, s. 12; 1959, c. 179, ss. 1, 2; 1969, c. 546, s. 1; 1973, c. 476, s. 138; c. 742; 1979, c. 702, s. 4; 1981, c. 275, s. 1; 1997-443, s. 12.8A.)

**§§ 108A-32 through 108A-35: Repealed by Session Laws 1997-443, s. 12.14.**

**§ 108A-36. Assistance not assignable; checks payable to decedents.**

The assistance granted by this Article shall not be transferable or assignable at law or in equity; and none of the money paid or payable as assistance shall be subject to execution, levy, attachment, garnishment, or other legal processes, or to the operation of any bankruptcy or insolvency law.

In the event of the death of a public assistance recipient during or after the first day of the month for which assistance was previously authorized by the county social services board, or county director if waived, any public assistance check or checks payable to such recipient not endorsed prior to such recipient's death shall be delivered to the clerk of superior court and by him administered under the provisions of G.S. 28A-25-6. (1937, c. 288, ss. 17, 47; 1945, c. 615, s. 1; 1953, c. 213; 1969, c. 546, s. 1; 1971, c. 446, ss. 1, 2; 1977, c. 655, ss. 1, 2; 1981, c. 275, s. 1.)

**§ 108A-37. Personal representative for mismanaged public assistance.**

(a) Whenever a county director of social services shall determine that a recipient of assistance is unwilling or unable to manage such assistance to the extent that deprivation or hazard to himself or others results, the director shall file a petition before a district court or the clerk of superior court in the county alleging such facts and requesting the appointment of a personal representative to be responsible for receiving such assistance and to use it for the benefit of the recipient.

(b) Upon receipt of such petition, the court shall promptly hold a hearing, provided the recipient shall receive five days' notice in writing of the time and place of such hearing. If the court, sitting without a jury, shall find at the hearing that the facts alleged in the petition are true, it may appoint some responsible person as personal representative. The personal representative shall serve without compensation and be responsible to the court for the faithful performance of his duties. He shall serve until the director of social services or the recipient shows to the court that the personal representative is no longer required or is unsuitable. All costs of court relating to proceedings under this section shall be waived.

(c) Any recipient for whom a personal representative is appointed may appeal such appointment to superior court for a hearing de novo without a jury.

(d) All findings of fact made under the proceedings authorized by this section shall not be competent as evidence in any case or proceeding which concerns any subject matter other than that of appointing a personal representative. (1959, c. 1239, ss. 1, 3; 1961, c. 186; 1969, c. 546, s. 1; 1981, c. 275, s. 1.)

**§ 108A-38. Protective and vendor payments.**

When necessary to comply with any present or future federal law or regulation in order to obtain federal participation in public assistance payments, the payments may be made direct to vendors to reimburse them for goods and services provided the applicants or recipients, and may be made to protective payees who shall act for the applicant or recipient for receiving and

managing assistance. Payments to vendors and protective payees shall be made to the extent provided in, and in accordance with, rules of the Social Services Commission or the Department, which rules shall be subject to applicable federal laws and regulations. (1963, c. 380; 1969, c. 546, s. 1; c. 747; 1973, c. 476, s. 138; 1977, 2nd Sess., c. 1219, s. 20; 1981, c. 275, s. 1; 1997-443, s. 12.9.)

**§ 108A-39. Fraudulent misrepresentation.**

(a) Any person whether provider or recipient, or person representing himself as such, who willfully and knowingly and with intent to deceive makes a false statement or representation or who fails to disclose a material fact and as a result of making a false statement or representation or failing to disclose a material fact obtains, for himself or another person, attempts to obtain for himself or another person, or continues to receive or enables another person to continue to receive public assistance in the amount of not more than four hundred dollars ($400.00) is guilty of a Class 1 misdemeanor.

(b) Any person, whether provider or recipient, or person representing himself as such who willfully and knowingly with the intent to deceive makes a false statement or representation or fails to disclose a material fact and as a result of making a false statement or representation or failing to disclose a material fact, obtains for himself or another person, attempts to obtain for himself or another person, or continues to receive or enables another person to continue to receive public assistance in an amount of more than four hundred dollars ($400.00) is guilty of a Class I felony.

(c) As used in this section the word "person" means person, association, consortium, corporation, body politic, partnership, or other group, entity, or organization. (1937, c. 288, ss. 27, 57; 1963, cc. 1013, 1024, 1062; 1969, c. 546, s. 1; 1977, c. 604, s. 1; 1979, c. 510, s. 2; c. 907; 1981, c. 275, s. 1; 1993, c. 539, s. 813; 1994, Ex. Sess., c. 24, s. 14(c).)

**§ 108A-39.1: Repealed by Session Laws 1997-443, s. 12.14.**

**§ 108A-39.2: Repealed by Session Laws 1989 (Reg. Sess., 1990), c. 966, s. 3.**

Part 3. State-County Special Assistance.

**§ 108A-40. (Effective until contingency met – see note) Authorization of State-County Special Assistance Program.**

The Department is authorized to establish and supervise a State-County Special Assistance Program. This program is to be administered by county departments of social services under rules and regulations of the Social Services Commission. (1981, c. 275, s. 1; 2010-31, s. 10.19A(c).)

**§ 108A-40. (Effective once contingency met – see note) Authorization of State-County Special Assistance Program.**

The Department is authorized to establish and supervise a State-County Special Assistance Program. County departments of social services shall administer this program under rules and regulations of the Social Services Commission. (1981, c. 275, s. 1; 2010-31, s. 10.19A(c); 2021-180, s. 9A.3A(b); 2022-74, s. 9A.1(b).)

**§ 108A-41. (Effective until contingency met – see note) Eligibility.**

(a) Assistance shall be granted under this Part to all persons in adult care homes for care found to be essential in accordance with the rules and regulations adopted by the Social Services Commission and prescribed by G.S. 108A-42(b). As used in this Part, the term "adult care home" includes a supervised living facility for adults with intellectual and developmental disabilities licensed under Article 2 of Chapter 122C of the General Statutes.

(b) Assistance shall be granted to any person who meets all of the following criteria:

(1) Meets one of the following:

a. Is 65 years of age or older.

b. Is between the ages of 18 and 65, and is permanently and totally disabled or is legally blind pursuant to G.S. 111-11.

(2) **(Effective until contingency met – see Editor's note)** Has insufficient income or other resources to provide a reasonable subsistence compatible with decency and health as determined by the rules and regulations of the Social Services Commission; and.

(2) **(For contingent effective date, see Editor's note)** Has both (i) income at or below one hundred percent (100%) of the federal poverty level guidelines published by the United States Department of Health and Human Services and (ii) insufficient income or other resources to provide a reasonable subsistence compatible with decency and health as determined by the rules and regulations of the Social Services Commission.

(3) Is one of the following:

a. A resident of North Carolina for at least 90 days immediately prior to receiving this assistance.

b. Repealed by Session Laws 2014-100, s. 12D.1(c), effective November 1, 2014.

c. A person discharged from a State facility who was a patient in the facility as a result of an interstate mental health compact that requires the State to continue treating the person within the State. As used in this sub-subdivision the term State facility is a facility listed under G.S. 122C-181.

(c) When determining whether a person has insufficient resources to provide a reasonable subsistence compatible with decency and health, there shall be excluded from consideration the person's primary place of residence and the land on which it is situated, and in addition there shall be excluded real property contiguous with the person's primary place of residence in which the property tax value is less than twelve thousand dollars ($12,000).

(d) The county shall also have the option of granting assistance to Certain Disabled persons as defined in the rules and regulations adopted by the Social Services Commission. Nothing in this Part should be interpreted so as to preclude any individual county from operating any program of financial assistance using only county funds. (1949, s. 1038, s. 2; 1961, c. 186; 1969, c. 546, s. 1; 1973, c. 717, s. 1; 1977, 2nd Sess., c. 1252, s. 1; 1979, c. 702, s. 8; 1981, c. 275, s. 1; c. 849, s. 1; 1983, c. 14, s. 2; 1995, c. 535, s. 5; 1997-210, s. 1; 2001-209, s. 3; 2010-31, s. 10.19A(d); 2014-100, s. 12D.1(a)-(c).)

**§ 108A-41. (Effective once contingency met – see note) Eligibility.**

(a) The Department shall grant assistance under this Part to all persons residing in adult care homes, special care units, and in-home living arrangements for care found to be essential in

accordance with the rules and regulations adopted by the Social Services Commission and prescribed by G.S. 108A-42(b). As used in this Part, the term "adult care home" includes a supervised living facility for adults with intellectual and developmental disabilities licensed under Article 2 of Chapter 122C of the General Statutes.

(b) The Department shall grant assistance to any person described in subsection (a) of this section who meets all of the following criteria:

(1) Meets one of the following:
  a. Is 65 years of age or older.
  b. Is between the ages of 18 and 65, and is permanently and totally disabled or is legally blind pursuant to G.S. 111-11.

(1a) Needs placement in an adult care home or special care unit and either resides in an adult care home or special care unit or would seek placement in an adult care home or special care unit if not for the State-County Special Assistance Program.

(2) Has insufficient income or other resources to provide a reasonable subsistence compatible with decency and health as determined by the rules and regulations of the Social Services Commission. The following income limits are applicable for determining financial eligibility for State-County Special Assistance:
  a. The total countable monthly income for individuals residing in adult care home facilities or in-home living arrangements without a diagnosis of Alzheimer's disease or dementia shall not exceed the basic rate established in subsection (a) of G.S. 108A-42.1 plus a personal needs allowance in an amount determined by the General Assembly.
  b. The total countable monthly income for individuals residing in special care units or in-home living arrangements with a diagnosis of Alzheimer's disease or dementia shall not exceed the enhanced rate established in subsection (b) of G.S. 108A-42.1 plus a personal needs allowance in an amount determined by the General Assembly.

(3) Is one of the following:
  a. A resident of North Carolina for at least 90 days immediately prior to receiving this assistance.
  b. Repealed by Session Laws 2014-100, s. 12D.1(c), effective November 1, 2014.
  c. A person discharged from a State facility who was a patient in the facility as a result of an interstate mental health compact that requires the State to continue treating the person within the State. As used in this sub-subdivision the term State facility is a facility listed under G.S. 122C-181.

(c) When determining whether a person has insufficient resources to provide a reasonable subsistence compatible with decency and health, there shall be excluded from consideration the person's primary place of residence and the land on which it is situated, and in addition there shall be excluded real property contiguous with the person's primary place of residence in which the property tax value is less than twelve thousand dollars ($12,000).

(d) The county shall also have the option of granting assistance to Certain Disabled persons as defined in the rules and regulations adopted by the Social Services Commission. Nothing in this Part should be interpreted so as to preclude any individual county from operating any program of

financial assistance using only county funds. (1949, s. 1038, s. 2; 1961, c. 186; 1969, c. 546, s. 1; 1973, c. 717, s. 1; 1977, 2nd Sess., c. 1252, s. 1; 1979, c. 702, s. 8; 1981, c. 275, s. 1; c. 849, s. 1; 1983, c. 14, s. 2; 1995, c. 535, s. 5; 1997-210, s. 1; 2001-209, s. 3; 2010-31, s. 10.19A(d); 2014-100, s. 12D.1(a)-(c); 2021-180, s. 9A.3A(b); 2022-74, s. 9A.1(b).)

**§ 108A-42. Determination of disability.**

(a) For purposes of G.S. 108A-41(b)(1), a person is permanently and totally disabled if:

(1) This person was receiving aid to the disabled assistance in December 1973, and continues to be disabled under the definition of disability, having a physical or mental impairment which substantially precludes him from obtaining gainful employment and this impairment appears reasonably certain to continue without substantial improvement throughout his lifetime; or

(2) This person applied for assistance on or after January 1, 1974, and is disabled under the Social Security standards.

(b) For purposes of G.S. 108A-41(d), a "Certain Disabled" person is a person in a private living arrangement who is age 18 but less than age 65, having a physical or mental impairment which substantially precludes him from obtaining gainful employment, which impairment appears reasonably certain to continue without substantial improvement throughout his lifetime.

(c) Disability shall be reviewed by medical consultants employed by the Department. The final decision on the disability shall be made by these medical consultants under rules and regulations adopted by the Social Services Commission. (1979, c. 702, s. 9; 1981, c. 275, s. 1; 1983, c. 14, s. 1.)

**§ 108A-42.1. (Effective once contingency met – see note) State-County Special Assistance Program payment rates.**

(a) Basic Rate. – The maximum monthly rate for State-County Special Assistance recipients residing in adult care homes or in-home living arrangements without a diagnosis of Alzheimer's disease or dementia shall be one thousand one hundred eighty-two dollars ($1,182) per month per resident. This rate shall be adjusted on January 1, 2023, and each January 1 thereafter, using the federally approved Social Security cost-of-living adjustment effective for the applicable year.

(b) Enhanced Rate. – The maximum monthly rate for State-County Special Assistance recipients residing in special care units or in-home living arrangements with a diagnosis of Alzheimer's disease or dementia shall be one thousand five hundred fifteen dollars ($1,515) per month per resident. This rate shall be adjusted on January 1, 2023, and each January 1 thereafter, using the federally approved Social Security cost-of-living adjustment effective for the applicable year. (2021-180, s. 9A.3A(b); 2022-74, s. 9A.1(a), (b).)

**§ 108A-43. Application procedure.**

(a) Applications under this Part shall be made to the county director of social services who, with the approval of the county board of social services and in conformity with the rules and regulations of the Social Services Commission, shall determine whether assistance shall be granted and the amount of such assistance; but the county board of social services may delegate to the county director the authority to approve or reject all applications for assistance under this Part, in which event the county director shall not be required to report his actions to the board.

(b) The amount of assistance which any eligible person may receive shall be determined with regard to the resources and necessary expenditures of the applicant, in accordance with the appropriate rules and regulations of the Social Services Commission. (1949, c. 1038, s. 2; 1961, c. 186; 1969, c. 546, s. 1; 1973, c. 476, s. 138; c. 717, s. 4; 1981, c. 275, s. 1.)

**§ 108A-44. State funds to counties.**

(a) Appropriations made under this Part by the General Assembly to the Department, together with grants of the federal government (when such grants are made available to the State) shall be used exclusively for assistance to needy persons eligible under this Part.

(b) Allotments shall be made annually by the Department to the counties participating in the program established by this Part.

(c) No allotment shall be used, either directly or indirectly, to replace county appropriations or expenditures. (1949, c. 1038, s. 2; 1955, c. 310, s. 3; 1961, c. 186; 1969, c. 546, s. 1; 1973, c. 717, s. 5; 1975, c. 92, s. 2; 1981, c. 275, s. 1.)

**§ 108A-45. Participation.**

The State-County Special Assistance Program established by this Part shall be administered by all the county departments of social services under rules and regulations adopted by the Social Services Commission and under the supervision of the Department. Provided that, assistance for certain disabled persons shall be provided solely at the option of the county. (1949, c. 1038, s. 2; 1969, c. 546, s. 1; 1973, c. 476, s. 138; c. 717, s. 6; 1975, c. 92, s. 3; 1977, 2nd Sess., c. 1252, s. 2; 1981, c. 275, s. 1; 2010-31, s. 10.19A(e).)

**§ 108A-46:** Repealed by Session Laws 2003-284, s. 10.53(a), effective July 1, 2003.

**§ 108A-46.1. Transfer of assets for purposes of qualifying for State-county Special Assistance.**

Notwithstanding any other provision of law to the contrary, Supplemental Security Income (SSI) policy applicable to transfer of assets and estate recovery, as prescribed by federal law, shall apply to applicants for State-county Special Assistance. (2003-284, s. 10.53(b); 2010-31, s. 10.19A(f).)

**§ 108A-47. Limitations on payments.**

No payment of assistance under this Part shall be made for the care of any person in a licensed facility that is owned or operated in whole or in part by any of the following:

(1) A member of the Social Services Commission, of any county board of social services, or of any board of county commissioners;

(2) An official or employee of the Department, unless the official or employee has been appointed temporary manager of the facility pursuant to G.S. 131E-237, or of any county department of social services;

(3) A spouse of a person designated in subdivisions (1) and (2). (1979, c. 702, s. 10; 1981, c. 275, s. 1; 1995, c. 298, s. 1; c. 535, s. 6; 2010-31, s. 10.19A(g).)

**§ 108A-47.1. (Contingently repealed – see note) Special Assistance in-home payments.**

(a) The Department of Health and Human Services may use funds from the existing State-County Special Assistance budget to provide Special Assistance payments to eligible

individuals 18 years of age or older in in-home living arrangements. These payments may be made for up to fifteen percent (15%) of the caseload for all State-County Special Assistance. The standard monthly payment to individuals enrolled in the Special Assistance in-home program shall be one hundred percent (100%) of the monthly payment the individual would receive if the individual resided in an adult care home and qualified for Special Assistance, except if a lesser payment amount is appropriate for the individual as determined by the local case manager. The Department shall implement Special Assistance in-home eligibility policies and procedures to assure that in-home program participants are those individuals who need and, but for the in-home program, would seek placement in an adult care home facility. The Department's policies and procedures shall include the use of a functional assessment.

(b) All county departments of social services shall participate in the State-County Special Assistance in-home program by making Special Assistance in-home slots available to individuals who meet the eligibility requirements established by the Department pursuant to subsection (a) of this section. By February 15, 2013, the Department shall establish a formula to determine the need for additional State-County Special Assistance in-home slots for each county. Beginning July 1, 2014, and each July 1 thereafter, the Department shall review and revise the formula as necessary. (2007-323, s. 10.14(a); 2010-31, s. 10.19A(h); 2012-142, s. 10.23(a); 2021-180, s. 9A.3; repealed by 2022-74, 2022-74, s. 9A.1(b).)

Part 4. Foster Care and Adoption Assistance Payments.

**§ 108A-48. State Foster Care Benefits Program.**

(a) The Department is authorized to establish a State Foster Care Benefits Program with appropriations by the General Assembly for the purpose of providing assistance to children who are placed in foster care facilities by county departments of social services in accordance with the rules and regulations of the Social Services Commission. Such appropriations, together with county contributions for this purpose, shall be expended to provide for the costs of keeping children in foster care facilities.

(b) Repealed by Session Laws 2015-241, s. 12C.9(a).

(c) The Department may continue to provide benefits pursuant to this section to an individual who has attained the age of 18 years and chosen to continue receiving foster care services until reaching 21 years of age if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this subsection due to a medical condition or disability.

(d) With monthly supervision and oversight by the director of the county department of social services or a supervising agency, an individual receiving benefits pursuant to subsection (c) of this section may reside outside a foster care facility in a college or university dormitory or other semi-supervised housing arrangement approved by the director of the county department of social services and continue to receive benefits pursuant to this section. (1981, c. 275, s. 1; 2015-241, s. 12C.9(a).)

**§ 108A-49. Foster care and adoption assistance payments.**

(a) Benefits in the form of foster care assistance shall be granted in accordance with the rules of the Social Services Commission to any dependent child who would have been eligible to

receive Aid to Families with Dependent Children (as that program was in effect on June 1, 1995), but for his or her removal from the home of a specified relative for placement in a foster care facility; provided, that the child's placement and care is the responsibility of a county department of social services. A county department of social services shall pay, at a minimum, the monthly graduated foster care assistance payments for eligible children as set by the General Assembly. A county department of social services may make foster care assistance payments in excess of the monthly graduated rates set by the General Assembly.

(b) Adoption assistance payments for certain adoptive children shall be granted in accordance with the rules of the Social Services Commission to adoptive parents who adopt a child eligible to receive foster care maintenance payments or supplemental security income benefits; provided, that the child cannot be returned to his or her parents; and provided, that the child has special needs which create a financial barrier to adoption. A county department of social services shall pay, at a minimum, the monthly graduated adoption assistance payments for eligible children as set by the General Assembly. A county department of social services may make adoption assistance payments in excess of the monthly graduated rates set by the General Assembly.

(c) The Department is authorized to use available federal payments to states under Title IV-E of the Social Security Act for foster care and adoption assistance payments.

(d) Except as otherwise prohibited by federal law, the Department of Health and Human Services, Division of Social Services, shall not require a redetermination of a child's eligibility for vendor payments under any adoption assistance agreement established prior to July 1, 2011. Nothing in this subsection shall make vendor assistance an entitlement.

(e) If all other eligibility criteria are met, adoption assistance payments may continue until the beneficiary reaches the age of 21 if the beneficiary was adopted after reaching the age of 16 but prior to reaching the age of 18. (1981, c. 275, s. 1; 1997-443, s. 12.10; 1999-190, s. 3; 2011-383, s. 1; 2015-241, s. 12C.9(b).)

**§ 108A-49.1. Foster care and adoption assistance payment rates.**

(a) The maximum rates for State participation in the foster care assistance program are established on a graduated scale as follows:

(1) $514.00 per child per month for children from birth through five years of age.
(2) $654.00 per child per month for children six through 12 years of age.
(3) $698.00 per child per month for children at least 13 but less than 21 years of age.

(b) The maximum rates for the State adoption assistance program are established consistent with the foster care rates as follows:

(1) $514.00 per child per month for children from birth through five years of age.
(2) $654.00 per child per month for children six through 12 years of age.
(3) $698.00 per child per month for children at least 13 but less than 21 years of age.

(c) The maximum rates for the State participation in human immunodeficiency virus (HIV) foster care and adoption assistance are established on a graduated scale as follows:

(1) $800.00 per child per month with indeterminate HIV status.
(2) $1,000 per child per month with confirmed HIV infection, asymptomatic.
(3) $1,200 per child per month with confirmed HIV infection, symptomatic.
(4) $1,600 per child per month when the child is terminally ill with complex care needs.

In addition to providing board payments to foster and adoptive families of HIV-infected children, any additional funds remaining that are appropriated for purposes described in this subsection shall be used to provide medical training in avoiding HIV transmission in the home.

(d) The State and a county participating in foster care and adoption assistance shall each contribute fifty percent (50%) of the nonfederal share of the cost of care for a child placed by a county department of social services or child-placing agency in a family foster home or residential child care facility. A county shall be held harmless from contributing fifty percent (50%) of the nonfederal share of the cost for a child placed in a family foster home or residential child care facility under an agreement with that provider as of October 31, 2008, until the child leaves foster care or experiences a placement change.

(e) A county shall be held harmless from contributing fifty percent (50%) of the nonfederal share of the cost for an individual receiving benefits pursuant to G.S. 108A-48(c). (2011-145, s. 10.51; 2015-241, s. 12C.9(c); 2021-180, s. 9I.11(a).)

**§ 108A-50. State benefits for certain adoptive children.**

(a) The Department is authorized to establish a program of State benefits for certain adoptive children from appropriations made by the General Assembly and from grants available from the federal government to the State. This program shall be used exclusively for the purpose of meeting the needs of adoptive children who are physically or mentally handicapped, older, or otherwise hard to place for adoption.

(b) The purpose of this program is to encourage, within the limits of available funds, the adoption of certain hard-to-place children in order to make it possible for children living in, or likely to be placed in foster homes or institutions, to benefit from the stability and security of permanent homes where such children can receive continuous care, guidance, protection and love to reduce the number of such children who might be placed or remain in foster homes or institutions until they become adults.

(c) Eligibility for an adoptive child to receive assistance shall be determined by the Department under the rules and regulations of the Social Services Commission.

(d) Financial assistance under this program shall not be provided when the needed services are available free of cost to the adoptive child; or are covered by an insurance policy of the adoptive parents; or are available to the child under the Adoption Assistance Program specified in G.S. 108A-49. (1975, c. 953, s. 3; 1981, c. 275, s. 1.)

**§ 108A-50.1. Special Needs Adoptions Incentive Fund.**

(a) There is created a Special Needs Adoptions Incentive Fund to provide financial assistance to facilitate the adoption of certain children residing in licensed foster care homes. These funds shall be used to remove financial barriers to the adoption of these children and shall be available to foster care families who adopt children with special needs, as defined by the Social Services Commission. These funds shall be matched by county funds.

(b) This program shall not constitute an entitlement and is subject to the availability of funds.

(c) The Social Services Commission shall adopt rules to implement the provisions of this section. (2003-284, s. 10.45.)

**§ 108A-50.2. Adoption Promotion Fund.**

(a) Funds appropriated by the General Assembly to the Department of Health and Human Services, Division of Social Services, for the Adoption Promotion Fund shall be used as provided in this section. The Division of Social Services of the Department of Health and Human Services, in consultation with the North Carolina Association of County Directors of Social Services and representatives of licensed private adoption agencies, shall develop guidelines for the awarding of funds to licensed public and private adoption agencies upon the adoption of children described in G.S. 108A-50 and in foster care. Payments received from the Adoption Promotion Fund by participating agencies shall be used exclusively to enhance the adoption services. No local match shall be required as a condition for receipt of these funds. In accordance with State rules for allowable costs, the Adoption Promotion Fund may be used for post-adoption services for families whose income exceeds two hundred percent (200%) of the federal poverty level.

(b) Of the total funds appropriated for the Adoption Promotion Fund each year, twenty percent (20%) of the total funds available shall be reserved for payment to participating private adoption agencies. If the funds reserved in this subsection for payments to private agencies have not been spent on or before March 31 of each State fiscal year, the Division of Social Services may reallocate those funds, in accordance with this section, to other participating adoption agencies.

(c) The Division of Social Services shall monitor the total expenditures in the Adoption Promotion Fund and redistribute unspent funds to ensure that the funds are used in accordance with the guidelines established in subsection (a) of this section. (2009-451, s. 10.48; 2013-360, s. 12C.10(c).)

## Part 5. Food and Nutrition Services.

### § 108A-51. Authorization for Food and Nutrition Services.

The Department is authorized to establish a statewide food and nutrition services program as authorized by the Congress of the United States. The Department of Health and Human Services is designated as the State agency responsible for the supervision of the food and nutrition services program. The boards of county commissioners through the county departments of social services are held responsible for the administration and operation of the food and nutrition services program. (1981, c. 275, s. 1; 1997-443, s. 11A.118(a); 2007-97, s. 9.)

### § 108A-51.1. Prohibition on certain waivers.

Except for waivers for the Disaster Supplemental Nutrition Assistance Program sought for an area that has received a Presidential disaster declaration of Individual Assistance from the Federal Emergency Management Agency, the Department shall not seek waivers to time limits established by federal law for food and nutrition benefits for able-bodied adults without dependents required to fulfill work requirements to qualify for those benefits. (2015-294, s. 16(a).)

### § 108A-52. Determination of eligibility.

Any person who believes that he or another person is eligible to receive electronic food and nutrition benefits may apply for such assistance to the county department of social services in the county in which the applicant resides. The application shall be made in such form and shall contain such information as the Social Services Commission may require. Upon receipt of an application for electronic food and nutrition benefits, the county department of social services shall make a prompt evaluation or investigation of the facts alleged in the application in order to determine the applicant's eligibility for such assistance and to obtain such other information as the Department

may require. Upon the completion of such investigation, the county department of social services shall, within a reasonable period of time, determine eligibility. (1981, c. 275, s. 1; 2007-97, s. 10.)

**§ 108A-53. Fraudulent misrepresentation.**

(a) Any person, whether provider or recipient or person representing himself as such, who knowingly obtains or attempts to obtain, or aids or abets any person to obtain by means of making a willfully false statement or representation or by impersonation or by failing to disclose material facts or in any manner not authorized by this Part or the regulations issued pursuant thereto, transfers with intent to defraud any electronic food and nutrition benefit to which that person is not entitled in the amount of four hundred dollars ($400.00) or less shall be guilty of a Class 1 misdemeanor. Whoever knowingly obtains or attempts to obtain, or aids or abets any person to obtain by means of making a willfully false statement or representation or by impersonation or by failing to disclose material facts or in any manner not authorized by this Part or the regulations issued pursuant thereto, transfers with intent to defraud any electronic food and nutrition benefit to which he is not entitled in an amount more than four hundred dollars ($400.00) shall be guilty of a Class I felony.

(b) Whoever presents, or causes to be presented, electronic food and nutrition benefits for payment or redemption, knowing the same to have been received, transferred, or used in any manner in violation of the provisions of this Part or the regulations issued pursuant to this Part shall be guilty of a Class 1 misdemeanor.

(c) Whoever receives any electronic food and nutrition benefits for any consumable item knowing that such benefits were procured fraudulently under subsections (a) and/or (b) of this section shall be guilty of a Class 1 misdemeanor.

(d) Whoever receives any electronic food and nutrition benefits for any consumable item whose exchange is prohibited by the United States Department of Agriculture shall be guilty of a Class 1 misdemeanor. (1981, c. 275, s. 1; 1991, c. 523, s. 5; 1993, c. 539, ss. 814, 1299; 1994, Ex. Sess., c. 24, s. 14(c); 1995, c. 507, s. 19.5(n); 1996, 2nd Ex. Sess., c. 18, s. 24.31(a); 2007-97, s. 11; 2008-187, s. 18.)

**§ 108A-53.1. Illegal possession or use of electronic food and nutrition benefits.**

(a) Any person who knowingly buys, sells, distributes, or possesses with the intent to sell, or distribute electronic food and nutrition benefits or access devices in any manner contrary to that authorized by this Part or the regulations issued pursuant thereto shall be guilty of a Class H felony.

(b) Any person who knowingly uses, transfers, acquires, alters, or possesses electronic food and nutrition benefits or access devices in any manner contrary to that authorized by this Part or the regulations issued pursuant thereto, other than as set forth in subsection (a) of this section, shall be guilty of a Class 1 misdemeanor if the value of such electronic food and nutrition benefits or access devices is less than one hundred dollars ($100.00), or a Class A1 misdemeanor if the value of such electronic food and nutrition benefits or access devices is equal to at least one hundred dollars ($100.00) but less than five hundred dollars ($500.00), or a Class I felony if the value of such electronic food and nutrition benefits or access devices is equal to at least five hundred dollars ($500.00) but less than one thousand dollars ($1,000), or a Class H felony if the value of such electronic food and nutrition benefits or access devices equals or exceeds one thousand dollars ($1,000). (1997-497, s. 2; 2007-97, s. 12.)

Part 6. Medical Assistance Program.

**§ 108A-54. (Effective until contingency met – see note) Authorization of Medical Assistance Program; administration.**

(a) The Department is authorized to establish a Medicaid Program in accordance with Title XIX of the federal Social Security Act. The Department may adopt rules to implement the Program. The State is responsible for the nonfederal share of the costs of medical services provided under the Program. In addition, the State shall pay one hundred percent (100%) of the federal Medicare Part D clawback payments under the Medicare Modernization Act of 2004, P.L. 108-173, as amended. A county is responsible for the county's cost of administering the Program in that county.

(b) Recodified as G.S. 108A-54.1B(a) by Session Laws 2013-360, s. 12H.9(a), effective July 1, 2013.

(c) The Medicaid Program shall be administered and operated in accordance with this Part and the North Carolina Medicaid State Plan and Waivers, as periodically amended by the Department of Health and Human Services in accordance with G.S. 108A-54.1A and approved by the federal government.

(d) The Department of Health and Human Services shall ensure that the North Carolina Families Accessing Services through Technology (NC FAST) information technology system can provide Medicaid eligibility determinations for the federally facilitated Health Benefit Exchange that will operate in North Carolina and shall provide such determinations for the Exchange.

(e) The Department of Health and Human Services shall continue to administer and operate the Medicaid and NC Health Choice programs through the Division of Medical Assistance until the Division of Medical Assistance is eliminated at which time all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance are vested in the Division of Health Benefits. Prior to and following the exchange of powers and duties from the Division of Medical Assistance to the Division of Health Benefits, and in addition to the powers and duties already vested in the Secretary of the Department of Health and Human Services, the Secretary of the Department of Health and Human Services shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for the Medicaid program and NC Health Choice program. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Employ clerical and professional staff of the Division of Health Benefits, including consultants and legal counsel, necessary to carry out the powers and duties of the division. In hiring staff for the Division of Health Benefits, the Secretary may offer employment contracts for a term and set compensation for the employees, which may include performance-based bonuses based on meeting budget or other targets.

(3) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(4) Establish and adjust all program components, except for eligibility categories, resource limits, and income thresholds, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.

(5) Adopt rules related to the Medicaid and NC Health Choice programs.

(6) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.

(7) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(8) Develop and present to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Office of State Budget and Management by January 1 of each year, beginning in 2017, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Department in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.

c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(9) Publish on its Web site and update on at least a monthly basis, at a minimum, the following information about the Medicaid and NC Health Choice programs:

a. Enrollment by program aid category by county.

b. Per member per month spending by category of service.

c. Spending and receipts by fund along with a detailed variance analysis.

d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(f) The General Assembly shall determine the eligibility categories, resource limits, and income thresholds for the Medicaid and NC Health Choice programs. The Department of Health and Human Services is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with the parameters set by the General Assembly.

(g) Repealed by Session Laws 2016-121, s. 2(h), effective June 1, 2016. (1965, c. 1173, s. 1; 1969, c. 546, s. 1; 1973, c. 476, s. 138; 1977, 2nd Sess., c. 1219, s. 24; 1981, c. 275, s. 1; 2007-323, s. 31.16.1(c); 2008-107, s. 10.10(c); 2011-399, s. 5; 2012-75, s. 1; 2013-5, s. 2; 2013-360, ss. 12H.3, 12H.9(a); 2013-363, s. 4.9(a); 2015-245, s. 13; 2016-94, s. 12H.4; 2016-121, s. 2(h); 2018-5, s. 11H.10(a), (b).)

**§ 108A-54. (Effective once contingency met – see note) Authorization of Medical Assistance Program; administration.**

(a) The Department is authorized to establish a Medicaid Program in accordance with Title XIX of the federal Social Security Act. The Department may adopt rules to implement the Program. The State is responsible for the nonfederal share of the costs of medical services provided under the Program. In addition, the State shall pay one hundred percent (100%) of the federal Medicare Part D clawback payments under the Medicare Modernization Act of 2004, P.L. 108-173, as amended. A county is responsible for the county's cost of administering the Program in that county.

(b) Recodified as G.S. 108A-54.1B(a) by Session Laws 2013-360, s. 12H.9(a), effective July 1, 2013.

(c) The Medicaid Program shall be administered and operated in accordance with this Part and the North Carolina Medicaid State Plan and Waivers, as periodically amended by the Department of Health and Human Services in accordance with G.S. 108A-54.1A and approved by the federal government.

(d) The Department of Health and Human Services shall ensure that the North Carolina Families Accessing Services through Technology (NC FAST) information technology system can provide Medicaid eligibility determinations for the federally facilitated Health Benefit Exchange that will operate in North Carolina and shall provide such determinations for the Exchange.

(e) The Department of Health and Human Services shall continue to administer and operate the Medicaid programs through the Division of Medical Assistance until the Division of Medical Assistance is eliminated at which time all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance are vested in the Division of Health Benefits. Prior to and following the exchange of powers and duties from the Division of Medical Assistance to the Division of Health Benefits, and in addition to the powers and duties already vested in the Secretary of the Department of Health and Human Services, the Secretary of the Department of Health and Human Services shall have the following powers and duties:

(1) Administer and operate the Medicaid programs, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for the Medicaid program. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid programs.

(2) Employ clerical and professional staff of the Division of Health Benefits, including consultants and legal counsel, necessary to carry out the powers and duties of the division. In hiring staff for the Division of Health Benefits, the Secretary may offer employment contracts for a term and set compensation for the employees, which may include performance-based bonuses based on meeting budget or other targets.

(3) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(4) Establish and adjust all program components, except for eligibility categories, resource limits, and income thresholds, of the Medicaid programs within the appropriated and allocated budget.

(5) Adopt rules related to the Medicaid programs.

(6) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid programs within budget.

(7) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid programs by other State departments or agencies.

(8) Develop and present to the Joint Legislative Oversight Committee on Medicaid and the Office of State Budget and Management by January 1 of each year, beginning in 2017, the following information for the Medicaid programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Department in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.
c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(9) Publish on its Web site and update on at least a monthly basis, at a minimum, the following information about the Medicaid programs:
a. Enrollment by program aid category by county.
b. Per member per month spending by category of service.
c. Spending and receipts by fund along with a detailed variance analysis.
d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(f) The General Assembly shall determine the eligibility categories, resource limits, and income thresholds for the Medicaid programs. The Department of Health and Human Services is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with the parameters set by the General Assembly.

(g) Repealed by Session Laws 2016-121, s. 2(h), effective June 1, 2016. (1965, c. 1173, s. 1; 1969, c. 546, s. 1; 1973, c. 476, s. 138; 1977, 2nd Sess., c. 1219, s. 24; 1981, c. 275, s. 1; 2007-323, s. 31.16.1(c); 2008-107, s. 10.10(c); 2011-399, s. 5; 2012-75, s. 1; 2013-5, s. 2; 2013-360, ss. 12H.3, 12H.9(a); 2013-363, s. 4.9(a); 2015-245, s. 13; 2016-94, s. 12H.4; 2016-121, s. 2(h); 2018-5, s. 11H.10(a), (b); 2022-74, s. 9D.15(z), (bb).)

**§ 108A-54.1:** Recodified as G.S. 108A-66.1 by Session Laws 2013-360, s. 12H.10(f), effective July 1, 2013.

**§ 108A-54.1A. (Effective until contingency met – see note) Amendments to Medicaid State Plan and Medicaid Waivers.**

(a) The Department of Health and Human Services is expressly authorized and required to take any and all necessary action to amend the State Plan and waivers in order to keep the program within the certified budget, except as provided in G.S. 108A-54(f). For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.

(b), (c) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(d) No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division that the amendment has been posted. For any amendments to the State Plan that add or eliminate an optional service, the notice required by this subsection shall be 90 days. This notice requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval.

(e) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(f) Any public notice required under 42 C.F.R. 447.205 shall, in addition to any other posting requirements under federal law, be posted on the Department's Web site. Upon posting such a public notice, the Department shall notify the members of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division that the public

notice has been posted. Public notices shall remain posted on the Department's Web site. (2013-360, s. 12H.2(a); 2014-100, s. 12H.21(a); 2015-245, s. 18.)

**§ 108A-54.1A. (Effective once contingency met – see note) Amendments to Medicaid State Plan and Medicaid Waivers.**

(a) The Department of Health and Human Services is expressly authorized and required to take any and all necessary action to amend the State Plan and waivers in order to keep the program within the certified budget, except as provided in G.S. 108A-54(f). For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.

(b), (c) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(d) No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division that the amendment has been posted. For any amendments to the State Plan that add or eliminate an optional service, the notice required by this subsection shall be 90 days. This notice requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval.

(e) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(f) Any public notice required under 42 C.F.R. 447.205 shall, in addition to any other posting requirements under federal law, be posted on the Department's Web site. Upon posting such a public notice, the Department shall notify the members of the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site. (2013-360, s. 12H.2(a); 2014-100, s. 12H.21(a); 2015-245, s. 18; 2022-74, s. 9D.15(z), (bb).)

**§ 108A-54.1B. Adoption of rules; State Plans, including amendments and waivers to State Plans, have effect of rules.**

(a) The Department is expressly authorized to adopt temporary and permanent rules to implement or define the federal laws and regulations, the North Carolina State Plan of Medical Assistance, and the North Carolina State Plan of the Health Insurance Program for Children, the terms and conditions of eligibility for applicants and recipients of the Medical Assistance Program and the Health Insurance Program for Children, audits and program integrity, the services, goods, supplies, or merchandise made available to recipients of the Medical Assistance Program and the Health Insurance Program for Children, and reimbursement for the services, goods, supplies, or merchandise made available to recipients of the Medical Assistance Program and the Health Insurance Program for Children.

(b) Rule-making authority granted under this section for particular circumstances or programs is in addition to any other rule-making authority granted to the Department under Chapter 150B of the General Statutes.

(c) Prior to filing a temporary rule authorized under G.S. 150B-21.1(a)(17) with the Rules Review Commission and the Office of Administrative Hearings, the Department shall consult with the Office of State Budget and Management on the possible fiscal impact of the temporary rule and its effect on State appropriations and local governments.

(d) **(Effective until contingency met – see note)** State Plans, State Plan Amendments, and Waivers approved by the Centers for Medicare and Medicaid Services (CMS) for the North

Carolina Medicaid Program and the NC Health Choice program shall have the force and effect of rules adopted pursuant to Article 2A of Chapter 150B of the General Statutes.

(d) **(Effective once contingency met – see note)** State Plans, State Plan Amendments, and Waivers approved by the Centers for Medicare and Medicaid Services (CMS) for the North Carolina Medicaid Program shall have the force and effect of rules adopted pursuant to Article 2A of Chapter 150B of the General Statutes. (2013-360, s. 12H.9(a), (b); 2022-74, s. 9D.15(g), (z).)

**§ 108A-54.2. (Effective until contingency met – see note) Procedures for changing medical policy.**

(a) The Department shall adopt rules to develop, amend, and adopt medical coverage policy for Medicaid and NC Health Choice in accordance with this section.

(b) Medical coverage policy is defined as those policies, definitions, or guidelines utilized to evaluate, treat, or support the health or developmental conditions of a recipient so as to determine eligibility, authorization or continued authorization, medical necessity, course of treatment and supports, clinical outcomes, and clinical supports treatment practices for a covered procedure, product, or service. Medical coverage policy is subject to the following:

(1) During the development of new medical coverage policy or amendment to existing medical coverage policy, the Department shall consult with and seek the advice of the Physician Advisory Group and other organizations the Secretary deems appropriate. The Secretary shall also consult with and seek the advice of officials of the professional societies or associations representing providers who are affected by the new medical coverage policy or amendments to existing medical coverage policy.

(2) At least 45 days prior to the adoption of new or amended medical coverage policy, the Department shall:

a. Publish the proposed new or amended medical coverage policy on the Department's Web site;

b. Notify all Medicaid and NC Health Choice providers of the proposed, new, or amended policy; and

c. Upon request, provide persons copies of the proposed medical coverage policy.

(3) During the 45-day period immediately following publication of the proposed new or amended medical coverage policy, the Department shall accept oral and written comments on the proposed new or amended policy.

(4) If, following the comment period, the proposed new or amended medical coverage policy is modified, then the Department shall, at least 15 days prior to its adoption:

a. Notify all Medicaid and NC Health Choice providers of the proposed policy;

b. Upon request, provide persons notice of amendments to the proposed policy; and

c. Accept additional oral or written comments during this 15-day period.

(c) If the adoption of new or amended medical coverage policies is necessitated by an act of the General Assembly or a change in federal law, then the 45- and 15-day time periods specified in subsection (b) of this section shall instead be 30- and 10-day time periods.

(d) Repealed by Session Laws 2015-245, s. 19, effective September 23, 2015. (2006-66, s. 10.4; 2009-451, s. 10.68A(b); 2011-399, s. 4; 2013-360, s. 12H.6(a); 2015-245, s. 19.)

**§ 108A-54.2. (Effective once contingency met – see note) Procedures for changing medical policy.**

(a) The Department shall adopt rules to develop, amend, and adopt medical coverage policy for Medicaid in accordance with this section.

(b) Medical coverage policy is defined as those policies, definitions, or guidelines utilized to evaluate, treat, or support the health or developmental conditions of a recipient so as to determine eligibility, authorization or continued authorization, medical necessity, course of treatment and supports, clinical outcomes, and clinical supports treatment practices for a covered procedure, product, or service. Medical coverage policy is subject to the following:

(1) During the development of new medical coverage policy or amendment to existing medical coverage policy, the Department shall consult with and seek the advice of the Physician Advisory Group and other organizations the Secretary deems appropriate. The Secretary shall also consult with and seek the advice of officials of the professional societies or associations representing providers who are affected by the new medical coverage policy or amendments to existing medical coverage policy.

(2) At least 45 days prior to the adoption of new or amended medical coverage policy, the Department shall:

a. Publish the proposed new or amended medical coverage policy on the Department's Web site;

b. Notify all Medicaid providers of the proposed, new, or amended policy; and

c. Upon request, provide persons copies of the proposed medical coverage policy.

(3) During the 45-day period immediately following publication of the proposed new or amended medical coverage policy, the Department shall accept oral and written comments on the proposed new or amended policy.

(4) If, following the comment period, the proposed new or amended medical coverage policy is modified, then the Department shall, at least 15 days prior to its adoption:

a. Notify all Medicaid providers of the proposed policy;

b. Upon request, provide persons notice of amendments to the proposed policy; and

c. Accept additional oral or written comments during this 15-day period.

(c) If the adoption of new or amended medical coverage policies is necessitated by an act of the General Assembly or a change in federal law, then the 45- and 15-day time periods specified in subsection (b) of this section shall instead be 30- and 10-day time periods.

(d) Repealed by Session Laws 2015-245, s. 19, effective September 23, 2015. (2006-66, s. 10.4; 2009-451, s. 10.68A(b); 2011-399, s. 4; 2013-360, s. 12H.6(a); 2015-245, s. 19; 2022-74, s. 9D.15(z).)

**§ 108A-54.3:** Repealed by Session Laws 2013-360, s. 12H.6(b), effective July 26, 2013.

**§ 108A-54.3A. Eligibility categories and income thresholds.**

The Department shall provide Medicaid coverage for individuals in accordance with federal statutes and regulations and specifically shall provide coverage for the following populations:

(1) Families, children under the age of 21, pregnant women, and individuals who are aged, blind, or disabled, who are medically needy, subject to the following annual income levels after meeting the applicable deductible:

| Family Size | Income Level |
|---|---|
| 1 | $2,904 |
| 2 | 3,804 |
| 3 | 4,404 |
| 4 | 4,800 |
| 5 | 5,196 |
| 6 | 5,604 |
| 7 | 6,000 |
| 8 | 6,300 |
| 9 | 6,504 |
| 10 | 6,900 |
| 11 | 7,200 |
| 12 | 7,596 |
| 13 | 8,004 |
| 14 | 8,400 |
| each additional family member | add $396 |

(2) Families and children under the age of 21, subject to the following annual income levels:

| Family Size | Income Level |
|---|---|
| 1 | $5,208 |
| 2 | 6,828 |
| 3 | 8,004 |
| 4 | 8,928 |
| 5 | 9,888 |
| 6 | 10,812 |
| 7 | 11,700 |
| 8 | 12,432 |
| 9 | 13,152 |
| 10 | 14,028 |
| each additional family member | add $936 |

(2a) **(Contingent effective date – see note)** A parent or caretaker relative, as defined in 42 C.F.R. § 435.4, who has qualified under subdivisions (1) and (2) of this section shall retain eligibility for Medicaid under this section so long as all of the following criteria are met:

a. The parent or caretaker relative has lost legal custody of a child pursuant to Subchapter I of Chapter 7B of the General Statutes.

b. A child of the parent or caretaker relative is temporarily in the legal custody of State-sponsored foster care or temporarily receiving foster care assistance under Title IV-E of the Social Security Act.

c. A court of competent jurisdiction has neither found that aggravated circumstances exist in accordance with G.S. 7B-901(c) nor found that a plan of reunification would be unsuccessful or inconsistent with the child's health or safety in accordance with G.S. 7B-906.1(d).

d. The parent or caretaker relative continues to meet the family income requirements under subdivision (1) or (2) of this section.

(3) **(Effective until contingency met – see note)** Children under the age of 6 with family incomes equal to or less than two hundred ten percent (210%) of the federal poverty guidelines.

(3) **(Effective once contingency met – see note)** Children through the age of 18 with family incomes equal to or less than two hundred ten percent (210%) of the federal poverty guidelines.

(4) **(Repealed effective when contingency met – see note)** Children aged 6 through 18 with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guidelines.

(5) Children under the age of 21 who are receiving foster care or adoption assistance under Title IV-E of the Social Security Act, without regard to income.

(6) Children in the legal custody of State-sponsored foster care who are under the age of 21 and ineligible for Title IV-E assistance, without regard to income.

(7) Independent foster care adolescents ages 18, 19, and 20, as defined in 42 U.S.C. § 1396d(w)(1), without regard to income.

(8) Former foster care children under the age of 26 in accordance with 42 U.S.C. § 1396a(a)(10)(A)(i)(IX), without regard to income.

(9) Adoptive children with special or rehabilitative needs, regardless of the adoptive family's income.

(10) **(Effective until March 31, 2027.)** Pregnant women with incomes equal to or less than one hundred ninety-six percent (196%) of the federal poverty guidelines. Pregnant women shall remain eligible for coverage for 12 months postpartum.

(10) **(Effective March 31, 2027.)** Pregnant women with incomes equal to or less than one hundred ninety-six percent (196%) of the federal poverty guidelines. Coverage for pregnant women eligible under this subdivision include only services related to pregnancy and to other conditions determined by the Department as conditions that may complicate pregnancy.

(11) Men and women of childbearing age with family incomes equal to or less than one hundred ninety-five percent (195%) of the federal poverty guidelines. Coverage for the individuals described in this subdivision shall be limited to coverage for family planning services.

(12) Women who need treatment for breast or cervical cancer and who are defined in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII).

(13) Aged, blind, or disabled individuals, as defined in Subpart F of Part 435 of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations,

with incomes equal to or less than one hundred percent (100%) of the federal poverty guidelines.

(14) Beneficiaries receiving supplemental security income under Title XVI of the Social Security Act.

(15) Workers with disabilities, as provided in G.S. 108A-66.1.

(16) Qualified working disabled individuals, as provided in G.S. 108A-67.

(17) Qualified Medicare beneficiaries with incomes equal to or less than one hundred percent (100%) of the federal poverty guidelines. Coverage for the individuals described in this subdivision shall be limited to payment of Medicare premiums and deductibles and coinsurance for Medicare-covered services.

(18) Specified low-income Medicare beneficiaries with incomes equal to or less than one hundred twenty percent (120%) of the federal poverty guidelines. Coverage for the individuals described in this subdivision shall be limited to payment of Medicare Part B premiums.

(19) Qualifying individuals who are Medicare beneficiaries and who have incomes equal to or less than one hundred thirty-five percent (135%) of the federal poverty guidelines may be covered within funds available for the Limited Medicare-Aid Capped Enrollment program. Coverage for the individuals described in this subdivision shall be limited to payment of Medicare Part B premiums.

(20) Recipients of an optional State supplementation program provided in accordance with 42 U.S.C. § 1382e.

(21) Individuals who meet eligibility criteria under a Medicaid waiver approved by the Centers for Medicare and Medicaid Services and authorized by an act of the General Assembly, within funds available for the waiver.

(22) Refugees, in accordance with 8 U.S.C. § 1522.

(23) Qualified aliens subject to the five-year bar for means tested public assistance under 8 U.S.C. § 1613 and undocumented aliens, only for emergency services under 8 U.S.C. § 1611. (2020-78, s. 4D.1; 2021-62, s. 4.3; 2021-180, ss. 9D.13(a), 9D.14(b); 2022-74, ss. 9D.14(e), 9D.15(c).)

**§ 108A-54.4. Income disregard for federal cost-of-living adjustments.**

An increase in a Medical Assistance Program recipient's income due solely to a cost-of-living adjustment to federal Social Security and Railroad Retirement payments shall be disregarded when determining income eligibility for the Medical Assistance Program. This section shall not be deemed to render a recipient eligible for the Medical Assistance Program if all other eligibility requirements are not met. (2012-142, s. 10.6(a); 2016-94, s. 12H.7.)

**§ 108A-54.5. Maintenance of waivers for dependents of members of Armed Forces.**

The Department of Health and Human Services shall ensure that the eligibility criteria for Medicaid home- and community-based waivers allow the dependent of a member of the Armed Forces of the United States to maintain the dependent's waiver status upon the transfer of the service member to an assignment outside of North Carolina, so long as the service member maintains the State of North Carolina as the legal residence to which the service member intends to return following completion of military service and the dependent meets Medicaid eligibility

criteria and all other waiver eligibility criteria upon returning to North Carolina. Consequently, a dependent who is on the waiting list for a waiver slot shall maintain the dependent's position on the waiting list. A dependent who was receiving waiver services prior to the service member's transfer, upon the dependent's return to North Carolina, shall be reinstated to the dependent's waiver slot, if the slot remains available, or shall receive a priority position on the waiting list for the next available waiver slot. This section shall not be construed to authorize the provision of waiver services outside of North Carolina. (2016-71, s. 1.)

**§ 108A-55. Payments.**

(a) The Department may authorize, within appropriations made for this purpose, payments of all or part of the cost of medical and other remedial care for any eligible person when it is essential to the health and welfare of such person that such care be provided, and when the total resources of such person are not sufficient to provide the necessary care. When determining whether a person has sufficient resources to provide necessary medical care, there shall be excluded from consideration the person's primary place of residence and the land on which it is situated, and in addition there shall be excluded real property contiguous with the person's primary place of residence in which the property tax value is less than twelve thousand dollars ($12,000).

(b) Payments shall be made only to intermediate care facilities, hospitals and nursing homes licensed and approved under the laws of the State of North Carolina or under the laws of another state, or to pharmacies, physicians, dentists, optometrists or other providers of health-related services authorized by the Department. Payments may also be made to such fiscal intermediaries and to the capitation or prepaid health service contractors as may be authorized by the Department. Arrangements under which payments are made to capitation or prepaid health services contracts are not subject to the provisions of Chapter 58 of the General Statutes or of Article 3 of Chapter 143 of the General Statutes. However, the Department shall: (i) submit all proposed contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all agreements or contracts to be awarded by the Department under this subsection a standard clause which provides that the State Auditor and internal auditors of the Department may audit the records of the contractor during and after the term of the contract to verify accounts and data affecting fees and performance. The Department shall not award a cost plus percentage of cost agreement or contract for any purpose.

(c) The Department shall reimburse providers of services, equipment, or supplies under the Medical Assistance Program in the following amounts:

(1) The amount approved by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services, if CMS approves an exact reimbursement amount.

(2) The amount determined by application of a method approved by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services, if CMS approves the method by which a reimbursement amount is determined, and not the exact amount.

The Department shall establish the methods by which reimbursement amounts are determined in accordance with Chapter 150B of the General Statutes. A change in a reimbursement amount becomes effective as of the date for which the change is approved by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services.

(d) No payments shall be made for the care of any person in a nursing home or intermediate care home which is owned or operated in whole or in part by a member of the Social Services Commission, of any county board of social services, or of any board of county commissioners, or by an official or employee of the Department or of any county department of social services or by a spouse of any such person.

(e) Medicaid is a secondary payor of claims. The Department shall apply Medicaid medical policy to recipients who have primary insurance other than Medicare, Medicare Advantage, and Medicaid. For recipients who have primary insurance other than Medicare, Medicare Advantage, or Medicaid, the Department shall pay the lesser of the Medicaid Allowable Amount or an amount up to the actual coinsurance or deductible or both of the primary payor, in accordance with the State Plan, as approved by the Department of Health and Human Services. The Department may disregard application of this policy in cases where application of the policy would adversely affect patient care.

(f) For payments made in fiscal year 2013-2014 and for subsequent fiscal years, the Department of Health and Human Services, Division of Health Benefits, shall publish on its Web site comprehensive information on Medicaid payments made to providers. The information shall be updated annually within three months of the close of a State fiscal year to include payments for that fiscal year. The information published shall include all of the following for each individual providing Medicaid services:

(1) Name of the individual providing the service.
(2) Location of service provider's principal place of business.
(3) Location of provided services, listed with both municipality and county. If an individual provides services in multiple locations, then those shall be specified and the items in subdivisions (6) through (10) of this subsection shall be provided for each location.
(4) Practice name, hospital name, or other business name with which the individual providing service is affiliated.
(5) Type of service provider and practice area.
(6) Number of Medicaid patients seen.
(7) Number of visits with Medicaid patients.
(8) Number of procedures performed or items furnished for Medicaid patients.
(9) Amount of Medicaid service payments received.
(10) Amount of Medicaid supplemental payments received.
(11) Amount of Medicaid settlement payments received.
(12) Amount of Medicaid recoupments.

The information shall be published in a character-separated values (CSV) plain text format or other file format that may easily be imported into software used for spreadsheets, databases, and data analytics. The Department shall ensure that no protected patient information be published. (1965, c. 1173, s. 1; 1969, c. 546, s. 1; 1971, c. 435; 1973, c. 476, s. 138; c. 644; 1975, c. 123, ss. 1, 2; 1977, 2nd Sess., c. 1219, c. 25; 1979, c. 702, s. 7; 1981, c. 275, s. 1; c. 849, s. 2; 1991, c. 388, s. 1; 1993, c. 529, s. 7.3; 1998-212, s. 12.12B(c); 2010-194, s. 15; 2011-291, s. 2.22; 2011-326, s. 15(o); 2013-360, s. 12H.4; 2014-100, ss. 12H.15(a), 12H.21(b); 2019-81, s. 15(a).)

**§ 108A-55.1. Medicare enrollment required.**

The Department shall require State Medical Assistance Program recipients who qualify for Medicare to enroll in Medicare, in accordance with Title XIX of the Social Security Act, in order

to pay medical expenditures that qualify for payment under Medicare Parts B and D, except that enrollment in Part D is not required if the recipient has creditable prescription drug coverage as defined by federal law.

Failure to enroll in Medicare shall result in nonpayment of these expenditures under the State Medical Assistance Program. A provider may seek payment for services from Medicaid enrollees who are eligible for but not enrolled in Medicare Parts B and D. (2003-284, s. 10.27; 2006-66, s. 10.6.)

**§ 108A-55.2. Collaboration among agencies to ensure Medicaid-related services payments to eligible students with disabilities in public schools.**

The Department shall work with the Department of Public Instruction and local education agencies to develop efficient, effective, and appropriate administrative procedures and guidelines to provide maximum funding for Medicaid-related services for Medicaid-eligible students with disabilities. The procedures and guidelines shall be streamlined to ensure that local education agencies receive Medicaid reimbursement in a timely manner for Medicaid-related services and administrative outreach to Medicaid-eligible students with disabilities. (2003-284, s. 10.29A.)

**§ 108A-55.3. Verification of State residency required for medical assistance.**

(a) At the time of application for medical assistance benefits, the applicant shall provide satisfactory proof that the applicant is a resident of North Carolina and that the applicant is not maintaining a temporary residence or abode incident to receiving medical assistance under this Part.

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

(1) A valid North Carolina drivers license or other identification card issued by the North Carolina Division of Motor Vehicles.

(2) A current North Carolina rent or mortgage payment receipt, or current utility bill in the name of the applicant or the applicant's legal spouse showing a North Carolina address.

(3) A valid North Carolina motor vehicle registration in the applicant's name and showing the applicant's current address.

(4) A document showing that the applicant is employed in this State.

(5) One or more documents proving that the applicant's domicile in the applicant's prior state of domicile has ended, such as closing of a bank account, termination of employment, or sale of a home.

(6) The tax records of the applicant or the applicant's legal spouse, showing a current North Carolina address.

(7) A document showing that the applicant has registered with a public or private employment service in this State.

(8) A document showing that the applicant has enrolled the applicant's children in a public or private school or child care facility located in this State.

(9) A document showing that the applicant is receiving public assistance or other services requiring proof of domicile, other than medical assistance, in this State.

(10) Records from a health department or other health care provider located in this State showing the applicant's current North Carolina address.

(11) A written declaration made under penalty of perjury from a person who has a social, family, or economic relationship with the applicant and who has 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.
(12) Current North Carolina voter registration card.
(13) A document from the U.S. Department of Veterans Affairs, U.S. Department of Defense, or the U.S. Department of Homeland Security verifying 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.
(14) Official North Carolina school records, signed by school officials, or diplomas issued by North Carolina schools, including secondary schools, community colleges, colleges, and universities verifying 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.
(15) Repealed by Session Laws 2015-294, s. 14, effective October 1, 2015, and applicable to contracts entered into on or after that date.

(c) For applicants, including those who are homeless or migrant laborers, who declare under penalty of perjury that they do not have two 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.

(d) The Division of Health Benefits shall not provide payment for medical assistance provided to an applicant unless or until the applicant has met the proof of residency requirements of this section.

(e) Unless otherwise provided for under Title 19 of the Social Security Act, a child under age 18 is a resident of the state where the child's parent or legal guardian is domiciled.

(f) This section does not apply to an applicant whose eligibility for medical assistance is excepted from State residency requirements under federal law.

(g) Nothing in this section shall be construed to establish North Carolina residency for a nonqualified alien who is present in North Carolina for a temporary or unspecified period of time unless the applicant is legally admitted for employment purposes. (2005-276, s. 10.21A(a); 2011-183, s. 74; 2015-294, s. 14; 2019-81, s. 15(a).)

**§ 108A-55.4. Insurers to provide certain information to Department of Health and Human Services.**

(a) As used in this section, the terms:
(1) "Applicant" means an applicant or former applicant of medical assistance benefits.

(1a) "Department" means the Department of Health and Human Services.

(2) "Division" means the Division of Health Benefits of the Department of Health and Human Services.

(3) "Health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, [29 USC Section 1167(1)]), service benefit plans, managed care organizations, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service as a condition of doing business in the State.

(4) "Medical assistance" means medical assistance benefits provided under the State Medical Assistance Plan.

(5), (6) Reserved for future codification.

(7) "Recipient" means a present or former recipient of medical assistance benefits.

(8) "Request" means any inquiry by the Department or Division for the purpose of determining the existence of insurance where the Department or Division may have expended public assistance benefits.

(9) "Subscriber" means the policyholder or covered person under the insurance policy.

(b) Health insurers, and pharmacy benefit managers regulated as third-party administrators under Article 56 of Chapter 58 of the General Statutes, shall provide, with respect to a subscriber upon request of the Division or its authorized contractor, information to determine during what period the individual or the individual's spouse or dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the subscriber's name, address, identification number, social security number, date of birth and identifying number of the plan) in a manner prescribed by the Division or its authorized contractor. Notwithstanding any other provision of law, every health insurer shall provide, not more frequently than twelve times in a year and at no cost, to the Department of Health and Human Services, Division of Health Benefits, or the Department's or Division's authorized contractor, upon its request, information as necessary so that the Division may (i) identify applicants or recipients who may also be subscribers covered under the benefit plans of the health insurer; (ii) determine the period during which the individual, the individual's spouse, or the individual's dependents may be or may have been covered by the health benefit plan; and (iii) determine the nature of the coverage. To facilitate the Division or its authorized contractor in obtaining this and other related information, every health insurer shall:

(1) Cooperate with the Division to determine whether a named individual who is a recipient of medical assistance may be covered under the insurer's health benefit plan and eligible to receive benefits under the health benefit plan for services provided under the State Medical Assistance Plan.

(2) Respond to the request for payment within 90 working days after receipt of written proof of loss or claim for payment for health care services provided to a recipient of medical assistance who is covered by the benefit plan of the health insurer.

(3) Accept the Division's right of recovery and the assignment to the Division of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State Medical Assistance Plan.

(4) Respond to any inquiry by the Division or its authorized contractor regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service.

(5) Notwithstanding subsection (d) of this section, agree not to deny a claim submitted by the Division solely on the basis of the date of submission of the claim, the type of format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if:

a. The claim is submitted by the Division within the three-year period beginning on the date on which the item or service was furnished; and

b. Any action by the Division to enforce its rights with respect to such claim is commenced within six years of the Division's submission of the claim.

(c) A health insurer that complies with this section shall not be liable on that account in any civil or criminal actions or proceedings.

(d) A health insurer is obligated to reimburse the Department only if the insurer has a contractual obligation to make payment for the covered service or item. (2006-66, s. 10.8; 2006-221, ss. 9(a)-(c); 2007-442, s. 2; 2019-81, s. 15(a).)

**§ 108A-55.5. Eligibility monitoring for medical assistance.**

(a) On at least a quarterly basis, the Department shall review information concerning changes in circumstances that may affect medical assistance beneficiaries' eligibility to receive medical assistance benefits. The Department shall share the information directly with, or make the information available to, the county department of social services that determined the beneficiary's eligibility.

(b) The information reviewed by the Department shall include all of the following:

(1) Earned and unearned income.

(2) Employment status and changes in employment.

(3) Residency status.

(4) Enrollment status in other State-administered public assistance programs.

(5) Financial resources.

(6) Incarceration status.

(7) Death records.

(8) Lottery winnings.

(9) Enrollment status in public assistance programs outside of this State.

(c) A county department of social services shall promptly review the information provided or made available by the Department in accordance with subsection (a) of this section to determine if the information indicates a change in circumstances that may affect a medical assistance beneficiary's eligibility to receive medical assistance benefits and take one of the following actions:

(1) If a review of the information does not result in the county department of social services finding a discrepancy or change in a beneficiary's circumstances that may affect that beneficiary's eligibility to receive medical assistance benefits, the county department of social services shall take no further action.

(2) If a review of the information does result in the county department of social services finding a discrepancy or change in a beneficiary's circumstances that may affect that beneficiary's eligibility for medical assistance benefits, the county department of social services shall provide written notice to the

beneficiary that describes in sufficient detail the circumstances of the discrepancy or change in circumstances that would affect the beneficiary's eligibility for medical assistance benefits. The notice must include the following information:

a. The beneficiary will have 12 calendar days from the time of mailing to respond.
b. A response from the beneficiary must be in writing.
c. Self-declarations made by the beneficiary will not be accepted as verification of information in the response.
d. The consequences of taking no action.

(d) After the expiration of 12 calendar days from the time of mailing the notice required under subsection (c) of this section, the county department of social services shall take one of the following actions:

(1) If a beneficiary did not respond to the notice, the county department of social services shall redetermine the beneficiary's eligibility for medical assistance benefits and provide the beneficiary with proper notice under G.S. 108A-79.
(2) If a beneficiary responds to the notice and disagrees with the information in the notice, the county department of social services shall reinvestigate the matter and take one of the following actions:
    a. If the county department of social services determines that there has been an error and the beneficiary's eligibility to receive medical assistance benefits is not affected, then no further action shall be taken.
    b. If the county department of social services determines that there is no error, the county department of social services shall redetermine the beneficiary's eligibility for medical assistance benefits and provide the beneficiary with proper notice under G.S. 108A-79.
(3) If a beneficiary responds to the notice and confirms the information in the notice is correct, then the county department of social services shall redetermine the beneficiary's eligibility for medical assistance benefits and provide the beneficiary with proper notice under G.S. 108A-79.

If, at any time after receiving a beneficiary's response to the notice, the county department of social services determines that there is a risk of fraud or misrepresentation or inadequate documentation, then the county department of social services may request additional documentation from the beneficiary.

(e) Nothing in this section shall preclude the Department or any county department of social services from receiving or reviewing additional information related to a beneficiary's eligibility for medical assistance benefits that is obtained in a manner other than that provided for under this section. (2017-57, s. 11H.20(a).)

**§ 108A-56. Acceptance of federal grants.**

All of the provisions of the federal Social Security Act providing grants to the states for medical assistance are accepted and adopted, and the provisions of this Part shall be liberally construed to effectuate compliance with the act, except to the extent the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. Nothing in this Part or the regulations made under its authority shall be construed to deprive a recipient of assistance of the right to choose the licensed provider of the care or service

made available under this Part within the provisions of the federal Social Security Act, or valid waiver agreement. This section shall not be construed to prohibit a PHP from (i) requiring its enrollees to obtain services from providers that are under contract with the PHP or (ii) imposing utilization management criteria to a request for services, to the extent these actions are not otherwise prohibited by State or federal law or regulation, or by the Department. (1965, c. 1173, s. 1; 1969, c. 546, s. 1; 1981, c. 275, s. 1; 2019-81, s. 4.)

**§ 108A-57. (Effective until contingency met – see note) Subrogation rights; withholding of information a misdemeanor.**

(a) As used in this section, the term "beneficiary" means (i) the beneficiary of medical assistance, including a minor beneficiary, (ii) the medical assistance beneficiary's parent, legal guardian, or personal representative, (iii) the medical assistance beneficiary's heirs, and (iv) the administrator or executor of the medical assistance beneficiary's estate.

Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State shall be subrogated to all rights of recovery, contractual or otherwise, of a beneficiary against any person. Any claim brought by a medical assistance beneficiary against a third party shall include a claim for all medical assistance payments for health care items or services furnished to the medical assistance beneficiary as a result of the injury or action, hereinafter referred to as the "Medicaid claim." Any claim brought by a medical assistance beneficiary against a third party that does not state the Medicaid claim shall be deemed to include the Medicaid claim. If the beneficiary has claims against more than one third party related to the same injury, then any amount received in payment of the Medicaid claim related to that injury shall reduce the total balance of the Medicaid claim applicable to subsequent recoveries related to that injury.

(a1) If the amount of the Medicaid claim does not exceed one-third of the medical assistance beneficiary's gross recovery, it is presumed that the gross recovery includes compensation for the full amount of the Medicaid claim. If the amount of the Medicaid claim exceeds one-third of the medical assistance beneficiary's gross recovery, it is presumed that one-third of the gross recovery represents compensation for the Medicaid claim.

(a2) A medical assistance beneficiary may dispute the presumptions established in subsection (a1) of this section by applying to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then to a court of competent jurisdiction in this State, for a determination of the portion of the beneficiary's gross recovery that represents compensation for the Medicaid claim. An application under this subsection shall be filed with the court and served on the Department pursuant to the Rules of Civil Procedure no later than 30 days after the date that the settlement agreement is executed by all parties and, if required, approved by the court, or in cases in which judgment has been entered, no later than 30 days after the date of entry of judgment. The court shall hold an evidentiary hearing no sooner than 60 days after the date the action was filed. All of the following shall apply to the court's determination under this subsection:

(1) The medical assistance beneficiary has the burden of proving by clear and convincing evidence that the portion of the beneficiary's gross recovery that represents compensation for the Medicaid claim is less than the portion presumed under subsection (a1) of this section.

(2) The presumption arising under subsection (a1) of this section is not rebutted solely by the fact that the medical assistance beneficiary was not able to recover the full amount of all claims.

(3) If the beneficiary meets its burden of rebutting the presumption arising under subsection (a1) of this section, then the court shall determine the portion of the recovery that represents compensation for the Medicaid claim and shall order the beneficiary to pay the amount so determined to the Department in accordance with subsection (a5) of this section. In making this determination, the court may consider any factors that it deems just and reasonable.

(4) If the beneficiary fails to rebut the presumption arising under subsection (a1) of this section, then the court shall order the beneficiary to pay the amount presumed pursuant to subsection (a1) of this section to the Department in accordance with subsection (a5) of this section.

(a3) Notwithstanding the presumption arising pursuant to subsection (a1) of this section, the medical assistance beneficiary and the Department may reach an agreement on the portion of the recovery that represents compensation for the Medicaid claim. If such an agreement is reached after an application has been filed pursuant to subsection (a2) of this section, a stipulation of dismissal of the application signed by both parties shall be filed with the court.

(a4) Within 30 days of receipt of the proceeds of a settlement or judgment related to a claim described in subsection (a) of this section, the medical assistance beneficiary or any attorney retained by the beneficiary shall notify the Department of the receipt of the proceeds.

(a5) The medical assistance beneficiary or any attorney retained by the beneficiary shall, out of the proceeds obtained by or on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount due pursuant to this section as follows:

(1) If, upon the expiration of the time for filing an application pursuant subsection (a2) of this section, no application has been filed, then the amount presumed pursuant to subsection (a1) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within 30 days of the beneficiary's receipt of the proceeds, in the absence of an agreement pursuant to subsection (a3) of this section.

(2) If an application has been filed pursuant to subsection (a2) of this section and no agreement has been reached pursuant to subsection (a3) of this section, then the Department shall be paid as follows:

a. If the beneficiary rebuts the presumption arising under subsection (a1) of this section, then the amount determined by the court pursuant to subsection (a2) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within 30 days of the entry of the court's order.

b. If the beneficiary fails to rebut the presumption arising under subsection (a1) of this section, then the amount presumed pursuant to subsection (a1) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within 30 days of the entry of the court's order.

(3) If an agreement has been reached pursuant to subsection (a3) of this section, then the agreed amount, as prorated with the claims of all others having medical

subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within 30 days of the execution of the agreement by the medical assistance beneficiary and the Department.

(a6) The United States and the State of North Carolina shall be entitled to shares in each net recovery by the Department under this section. Their shares shall be promptly paid under this section and their proportionate parts of such sum shall be determined in accordance with the matching formulas in use during the period for which assistance was paid to the recipient.

(b) It is a Class 1 misdemeanor for any person seeking or having obtained assistance under this Part for himself or another to willfully fail to disclose to the county department of social services or its attorney and to the Department the identity of any person or organization against whom the recipient of assistance has a right of recovery, contractual or otherwise.

(c) This section applies to the administration of and claims payments under the NC Health Choice Program established under Part 8 of this Article.

(d) As required to ensure compliance with this section, the Department may apply to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then to a court of competent jurisdiction in this State for enforcement of this section. (1973, c. 476, s. 138; c. 1031, s. 1; 1979, 2nd Sess., c. 1312, ss. 1, 2; 1981, c. 275, s. 1; 1987 (Reg. Sess., 1988), c. 1022; 1993, c. 539, s. 815; 1994, Ex. Sess., c. 24, s. 14(c); 1996, 2nd Ex. Sess., c. 18, s. 24.2(a); 2009-16, s. 4(c); 2013-274, s. 1; 2017-57, s. 11H.23; 2018-5, s. 11H.6(a); 2019-240, s. 11(a).)

**§ 108A-57. (Effective once contingency met – see note) Subrogation rights; withholding of information a misdemeanor.**

(a) As used in this section, the term "beneficiary" means (i) the beneficiary of medical assistance, including a minor beneficiary, (ii) the medical assistance beneficiary's parent, legal guardian, or personal representative, (iii) the medical assistance beneficiary's heirs, and (iv) the administrator or executor of the medical assistance beneficiary's estate.

Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State shall be subrogated to all rights of recovery, contractual or otherwise, of a beneficiary against any person. Any claim brought by a medical assistance beneficiary against a third party shall include a claim for all medical assistance payments for health care items or services furnished to the medical assistance beneficiary as a result of the injury or action, hereinafter referred to as the "Medicaid claim." Any claim brought by a medical assistance beneficiary against a third party that does not state the Medicaid claim shall be deemed to include the Medicaid claim. If the beneficiary has claims against more than one third party related to the same injury, then any amount received in payment of the Medicaid claim related to that injury shall reduce the total balance of the Medicaid claim applicable to subsequent recoveries related to that injury.

(a1) If the amount of the Medicaid claim does not exceed one-third of the medical assistance beneficiary's gross recovery, it is presumed that the gross recovery includes compensation for the full amount of the Medicaid claim. If the amount of the Medicaid claim exceeds one-third of the medical assistance beneficiary's gross recovery, it is presumed that one-third of the gross recovery represents compensation for the Medicaid claim.

(a2) A medical assistance beneficiary may dispute the presumptions established in subsection (a1) of this section by applying to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then to a court of competent jurisdiction in this State, for a determination of the portion of the beneficiary's gross recovery that represents

compensation for the Medicaid claim. An application under this subsection shall be filed with the court and served on the Department pursuant to the Rules of Civil Procedure no later than 30 days after the date that the settlement agreement is executed by all parties and, if required, approved by the court, or in cases in which judgment has been entered, no later than 30 days after the date of entry of judgment. The court shall hold an evidentiary hearing no sooner than 60 days after the date the action was filed. All of the following shall apply to the court's determination under this subsection:

(1) The medical assistance beneficiary has the burden of proving by clear and convincing evidence that the portion of the beneficiary's gross recovery that represents compensation for the Medicaid claim is less than the portion presumed under subsection (a1) of this section.

(2) The presumption arising under subsection (a1) of this section is not rebutted solely by the fact that the medical assistance beneficiary was not able to recover the full amount of all claims.

(3) If the beneficiary meets its burden of rebutting the presumption arising under subsection (a1) of this section, then the court shall determine the portion of the recovery that represents compensation for the Medicaid claim and shall order the beneficiary to pay the amount so determined to the Department in accordance with subsection (a5) of this section. In making this determination, the court may consider any factors that it deems just and reasonable.

(4) If the beneficiary fails to rebut the presumption arising under subsection (a1) of this section, then the court shall order the beneficiary to pay the amount presumed pursuant to subsection (a1) of this section to the Department in accordance with subsection (a5) of this section.

(a3) Notwithstanding the presumption arising pursuant to subsection (a1) of this section, the medical assistance beneficiary and the Department may reach an agreement on the portion of the recovery that represents compensation for the Medicaid claim. If such an agreement is reached after an application has been filed pursuant to subsection (a2) of this section, a stipulation of dismissal of the application signed by both parties shall be filed with the court.

(a4) Within 30 days of receipt of the proceeds of a settlement or judgment related to a claim described in subsection (a) of this section, the medical assistance beneficiary or any attorney retained by the beneficiary shall notify the Department of the receipt of the proceeds.

(a5) The medical assistance beneficiary or any attorney retained by the beneficiary shall, out of the proceeds obtained by or on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount due pursuant to this section as follows:

(1) If, upon the expiration of the time for filing an application pursuant subsection (a2) of this section, no application has been filed, then the amount presumed pursuant to subsection (a1) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within 30 days of the beneficiary's receipt of the proceeds, in the absence of an agreement pursuant to subsection (a3) of this section.

(2) If an application has been filed pursuant to subsection (a2) of this section and no agreement has been reached pursuant to subsection (a3) of this section, then the Department shall be paid as follows:

a. If the beneficiary rebuts the presumption arising under subsection (a1) of this section, then the amount determined by the court pursuant to subsection (a2) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within 30 days of the entry of the court's order.

b. If the beneficiary fails to rebut the presumption arising under subsection (a1) of this section, then the amount presumed pursuant to subsection (a1) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within 30 days of the entry of the court's order.

(3) If an agreement has been reached pursuant to subsection (a3) of this section, then the agreed amount, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within 30 days of the execution of the agreement by the medical assistance beneficiary and the Department.

(a6) The United States and the State of North Carolina shall be entitled to shares in each net recovery by the Department under this section. Their shares shall be promptly paid under this section and their proportionate parts of such sum shall be determined in accordance with the matching formulas in use during the period for which assistance was paid to the recipient.

(b) It is a Class 1 misdemeanor for any person seeking or having obtained assistance under this Part for himself or another to willfully fail to disclose to the county department of social services or its attorney and to the Department the identity of any person or organization against whom the recipient of assistance has a right of recovery, contractual or otherwise.

(c) **(For contingent repeal, see note)** This section applies to the administration of and claims payments under the NC Health Choice Program established under Part 8 of this Article.

(d) As required to ensure compliance with this section, the Department may apply to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then to a court of competent jurisdiction in this State for enforcement of this section. (1973, c. 476, s. 138; c. 1031, s. 1; 1979, 2nd Sess., c. 1312, ss. 1, 2; 1981, c. 275, s. 1; 1987 (Reg. Sess., 1988), c. 1022; 1993, c. 539, s. 815; 1994, Ex. Sess., c. 24, s. 14(c); 1996, 2nd Ex. Sess., c. 18, s. 24.2(a); 2009-16, s. 4(c); 2013-274, s. 1; 2017-57, s. 11H.23; 2018-5, s. 11H.6(a); 2019-240, s. 11(a); 2022-74, s. 9D.15(h).)

**§ 108A-57.1. Rules governing transfer of medical assistance benefits between counties.**

Any recipient of medical assistance who moves from one county to another county of this State shall continue to receive medical assistance if eligible. The county director of social services of the county from which the recipient has moved shall transfer all necessary records relating to the recipient to the county director of social services of the county to which the recipient has moved. The county from which the recipient has moved shall pay the county portion of the nonfederal share of medical assistance payments paid for services provided to the recipient during the month following the recipient's move. Thereafter, the county to which the recipient has moved shall pay the county portion of the nonfederal share of medical assistance payments paid for the services provided to the recipient. (1998-212, s. 12.6.)

**§ 108A-58:** Repealed by Session Laws 2006-66, s. 10.5(a), effective July 1, 2006.

**§ 108A-58.1. Ineligibility for medical assistance based on transferring assets for less than fair market value.**

(a) General Rule. – Except as otherwise provided herein, an individual who is otherwise eligible to receive medical assistance under this Part is ineligible for Medicaid coverage and payment for the services specified in subsection (d) during the period specified in subsection (c) if the individual or the individual's spouse transfers an asset for less than fair market value on or after the "lookback date" specified in subsection (b).

(b) Lookback Date. –

(1) Except as otherwise provided herein, the lookback date is the date specified in 42 U.S.C. § 1396p(c)(1)(B).

(2) Notwithstanding subdivision (1), the lookback date with respect to the medical services specified in subdivision (d)(2) is the date specified in 42 U.S.C. § 1396p(c)(1)(B) or February 1, 2003, whichever is later.

(c) Penalty Period. – The penalty period for the transfer of assets for less than fair market value is the period specified in 42 U.S.C. § 1396p(c)(1)(D), (E), and (H).

(d) Medical Services. –

(1) In the case of an institutionalized individual, the transfer of assets penalty applies with respect to nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and to home- or community-based services furnished under the State's Community Alternatives Program waiver pursuant to 42 U.S.C. § 1396n(c) or (d), and pursuant to the hardship waiver under subsection (k) of this section.

(2) In the case of a noninstitutionalized individual, the transfer of assets penalty applies with respect to home health services and personal care services as defined in 42 U.S.C. § 1396d(a)(7) and (24) and, to the extent permitted by federal law, such other long-term care services specified by rules adopted by the Department of Health and Human Services pursuant to subsection (k) of this section.

(e) Assets. – Assets are the income and resources of an individual or the individual's spouse (including the individual's or spouse's home) as defined in 42 U.S.C. § 1396p(h) and 42 U.S.C. § 1396p(c)(1)(G), (I), and (J).

(f) Fair Market Value and Uncompensated Value. –

(1) The fair market value of an asset is the value (minus any valid and legally enforceable liens, mortgages, and encumbrances against the asset) that would have been received if the asset had been sold for good and valuable consideration at the prevailing market price at the time the asset was transferred. In the case of real or personal property that is taxable under Subchapter II of Chapter 105 of the General Statutes, there is a rebuttable presumption that the fair market value of the property is its most recent value as ascertained under Subchapter II of Chapter 105 of the General Statutes (minus any valid and legally enforceable liens, mortgages, and encumbrances against the property).

(2) The uncompensated value of an asset is its fair market value minus the amount of good and valuable consideration received in exchange for the asset's transfer.

(g) Individual. – An individual is a person who applies for or is receiving medical assistance under this Part regardless of whether the person was, at the time an asset was transferred, a Medicaid applicant or recipient. The term "individual" also includes an individual's legal representative, anyone acting at the individual's direction or request, and any person, agency, or court acting lawfully on behalf of the individual.

(h) Institutionalized and Noninstitutionalized Individuals. –

(1) An institutionalized individual is an individual who meets the criteria set forth in 42 U.S.C. § 1396p(h)(3), regardless of whether the individual was institutionalized at the time an asset was transferred.

(2) A noninstitutionalized individual is any individual who (i) is not an institutionalized individual, (ii) is an aged, blind, or disabled person who is categorically or medically needy pursuant to 42 C.F.R. § 120 Subpart B, C, or D or a qualified Medicare beneficiary as defined in 42 U.S.C. § 1396d(p)(1), and (iii) is not eligible for medical assistance under this Part based on his or her eligibility for an optional State supplement pursuant to 42 C.F.R. § 435.232.

(i) Exceptions. –

(1) This section does not apply if an individual establishes by the greater weight of the evidence that the transfer was exclusively for some purpose other than establishing or retaining eligibility for medical assistance under this Part.

(2) This section does not apply to any transfer specified in 42 U.S.C. § 1396p(c)(2)(A), (B), (C)(i), or (C)(iii).

(j) Application to Life Estates and Income Producing Real Property. – The Department of Health and Human Services may apply federal transfer of assets policies in accordance with this section to (i) life estates purchased by or on behalf of the recipient, and (ii) to real property excluded as "income producing", tenancy-in-common, or as nonhomesite property made "income producing." The Department shall exclude from countable resources any life estate in real property that is in the recipient's home and is measured by the recipient's life. Federal transfer of assets policies applied to income producing real property shall become effective not earlier than October 1, 2001. Federal transfer of assets policies applied to real property excluded as tenancy-in-common, or as nonhomesite property made income producing in accordance with this subsection, shall become effective not earlier than October 1, 2005.

(k) Hardship Waiver. – The Department of Health and Human Services shall waive a transfer of assets penalty that has been imposed or is imposable under this section if the Department determines that imposition of the penalty would create an undue hardship.

(l) Rules and Compliance with Federal Law. –

(1) This section shall be interpreted and administered consistently with governing federal law, including 42 U.S.C. § 1396p(c).

(2) The Department of Health and Human Services shall determine and publish at least annually the average monthly cost of nursing facility services for private patients that will be used in determining the length of a penalty period under this section.

(3) The Department of Health and Human Services shall provide for a hardship waiver process in accordance with 42 U.S.C. § 1396p(c)(2)(D).

(4) The Department of Health and Human Services may adopt administrative rules that are necessary and appropriate to implement this section or the requirements

of 42 U.S.C. § 1396p(c) or other federal laws governing the transfer of assets and Medicaid eligibility. (2006-66, s. 10.5(b); 2006-221, ss. 8(a)-(c).)

**§ 108A-58.2. Waiver of transfer of assets penalty due to undue hardship.**

(a) Prior to imposition of a period of ineligibility for long-term care services because of an asset transfer, also known as a penalty period, the county department of social services shall notify the individual of the individual's right to request a waiver of the penalty period because it will cause an undue hardship to the individual. The director of the county department of social services, or the director's designee shall grant a waiver of the penalty period due to undue hardship if the individual meets the conditions set forth in subsection (e) of this section. As used in this section, "long term care services" are those services described in 42 U.S.C. § 1396p(c)(1)(C)(i) and (ii).

(b) When a Medicaid applicant who is requesting Medicaid to pay for institutional care requests a waiver of a penalty period due to undue hardship, the determination of whether to waive the penalty period shall be processed as part of the Medicaid application and is subject to the application processing standards set forth in 10A NCAC 23C.0201.

(c) When an ongoing Medicaid recipient applies for institutional care or is receiving Medicaid payment for institutional care receives the notice described in subsection (a) of this section, the recipient has 12 calendar days from the date of the notice to request a waiver of the penalty due to undue hardship. The following are the procedures for processing the waiver request:

(1) Within five work days of receipt of a request for a waiver of the transfer of assets penalty, the county department of social services shall notify the individual in writing of the information and documentation necessary to determine if the requirements for approving the undue hardship waiver are met.

(2) The individual shall have 12 calendar days from the date of the notice specified in subdivision (1) of this subsection to provide the necessary information and documentation to establish the undue hardship.

(3) If at the end of the first 12 calendar day period the necessary information and documentation has not been received by the county department of social services, the county department of social services shall again notify the individual of the necessary information and documentation. The individual shall be given an additional 12 calendar days to provide the information and documentation.

(4) If the individual fails to request the undue hardship waiver within 12 calendar days from the date of the notice described in subsection (a) of this section, the county department of social services shall impose the transfer of assets penalty in accordance with notice requirements in G.S. 108A-79.

(5) If by the end of the 12 calendar days from the notice described in subdivision (3) of this subsection, the necessary information and documentation has not been received by the county department of social services, the county department of social services shall deny the request for waiver of the penalty for undue hardship and notify the individual of the denial in accordance with G.S. 108A-79.

(6) If by the end of the time allowed under subdivisions (2) and (3) of this subsection the county department of social services has received the necessary information and documentation, the county department of social services shall make a determination of whether the imposition of the penalty period would

cause an undue hardship to the individual. The county department of social services shall complete the determination and notify the individual, pursuant to subsection (g) of this section, of whether the imposition of the penalty period will be waived due to undue hardship within 12 calendar days of the receipt of the necessary information and documentation.

(7) If as part of the determination described in subdivision (6) of this subsection the county department of social services identifies the need for additional information and documentation, it shall notify the individual in writing of that information and documentation. This notice shall initiate a new period of time for the individual to provide the information and documentation as set forth in subdivisions (2) and (3) of this subsection. Within 12 calendar days of the receipt of the additional information and documentation, the county department of social services shall complete the determination and notify the individual, pursuant to subsection (g) of this section, of whether the imposition of the penalty period will be waived due to undue hardship.

(d) As required by 42 U.S.C. § 1396p(c)(2)(D), the facility in which an institutionalized individual is residing may request an undue hardship waiver on behalf of the institutionalized individual with the written consent of the individual or the personal representative of the individual. A facility applying for a waiver for an individual residing in the facility shall adhere to the requirements of this section but is not required to advance the costs of acquiring an attorney to aid the institutionalized individual.

(e) Except as provided for in subsection (f) of this section, undue hardship exists if the imposition of the penalty period would deprive the individual of medical care, such that the individual's health or life would be endangered, or of food, clothing, shelter, or other necessities of life. The individual must provide the information and documentation necessary to demonstrate to the director of the county department of social services or the director's designee all of the following:

(1) The individual currently has no alternative income or resources available to provide the medical care or food, clothing, shelter, or other necessities of life that the individual would be deprived of due to the imposition of the penalty.

(2) The individual or some other person acting on the individual's behalf is making a good faith effort to pursue all reasonable means to recover the transferred asset or the fair market value of the transferred asset, including any of the following:

a. Seeking the advice of an attorney and pursuing legal or equitable remedies such as asset freezing, assignment, or injunction.

a1. Seeking modification, avoidance, or nullification of a financial instrument, promissory note, loan, mortgage or other property agreement, or other similar transfer agreement.

b. Cooperating with any attempt to recover the transferred asset or the fair market value of the transferred asset.

(3) The following definitions apply in this subsection:

a. Health or life would be endangered. – A medical doctor with knowledge of the individual's medical condition certifies in writing that in his or her professional opinion, the individual will be in danger of death or the

individual's health will suffer irreparable harm if a penalty period is imposed.

b. Recodified as sub-subdivision (e)(3)c1. of this section by Session Laws 2021-88, s. 9(a).

c. Income. – All income of the individual and the community spouse less a protected amount for the community spouse equal to the minimum monthly maintenance needs allowance as determined under 42 U.S.C. § 1396r-5(d), including in all circumstances the excess shelter allowance described under 42 U.S.C. § 1396r-5(d)(3)(A)(ii), without regard to any adjustment that would be made under 42 U.S.C. § 1396r-5(e), plus fifty percent (50%) of the income in excess of the protected amount.

c1. Other necessities of life. – Includes basic, life sustaining utilities, including water, heat, electricity, phone, and other items or activities that without which the individual's health or life would be endangered.

d. Resources. – All resources of the individual and of the community spouse except the homesite in which the individual or community spouse has an equity interest not exceeding five hundred thousand dollars ($500,000), a motor vehicle in which the individual or community spouse has an equity interest not exceeding thirty thousand dollars ($30,000), personal property, and, in the case of a community spouse, a portion of such other resources in an amount equal to the community spouse resource allowance as defined by 42 U.S.C. § 1396r-5(f)(2), so long as the amount does not exceed sixty percent (60%) of the maximum community spouse resource allowance as defined by 42 U.S.C. § 1396r-5(f)(2)(A)(ii). For purposes of this sub-subdivision, "homesite" means the principal place of residence of the individual or the community spouse in which the individual or community spouse has an equity interest.

(f) An undue hardship does not exist when the application of a transfer of assets penalty merely causes the individual an inconvenience or restricts the individual's lifestyle.

(g) If the director of the county department of social services or the director's designee determines that:

(1) An undue hardship exists, the county department of social services shall waive the penalty period and notify the individual of approval of the waiver of the penalty in accordance with G.S. 108A-79.

(2) An undue hardship does not exist, the county department of social services shall deny the request for the waiver of the penalty and notify the individual of denial of the waiver request in accordance with G.S. 108A-79.

(h) During a penalty period that has been waived because of undue hardship, acquisition by the individual of new or increased income or resources shall be treated as a change in situation and evaluated pursuant to the rules adopted by the Department of Health and Human Services.

(i) While the determination on a request for a waiver of the penalty period due to undue hardship is pending, Medicaid shall not make payments for services in a nursing facility or in an intermediate care facility for individuals with intellectual disabilities to hold a bed for the individual, as described in 42 U.S.C. § 1396p(c)(2)(D). However, if the individual is

institutionalized and receiving Medicaid payment for services, Medicaid will maintain the same level of services until the last day of the month after the latter of the following:

(1) Expiration of the 10 workday period following the notice required by G.S. 108A-79.

(2) The date of the decision of a local appeal hearing described in G.S. 108A-79 is issued if the individual requests an appeal of the imposition of a transfer of assets penalty period within the 10 workday period described in subdivision (1) of subsection (i) of this section. (2007-442, s. 3(a); 2021-62, s. 4.1; 2021-88, ss. 9(a), (b).)

**§ 108A-59. Acceptance of medical assistance constitutes assignment to the State of right to third party benefits; recovery procedure.**

(a) Notwithstanding any other provisions of the law, by accepting medical assistance, the recipient shall be deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which he may be entitled.

It shall be the responsibility of the county attorney of the county from which the medical assistance benefits are received or an attorney retained by that county and/or the State to enforce this subsection, and said attorney shall be compensated for his services in accordance with the attorneys' fee arrangements approved by the Department of Health and Human Services.

(b) The responsible State agency will establish a third party resources collection unit that is adequate to assure maximum collection of third party resources.

(c) Notwithstanding any other law to the contrary, in all actions brought pursuant to subsection (a) of this section to obtain reimbursement for payments for medical services, liability shall be determined on the basis of the same laws and standards, including bases for liability and applicable defenses, as would be applicable if the action were brought by the individual on whose behalf the medical services were rendered. (1977, c. 664; 1979, 2nd Sess., c. 1312, ss. 3-5; 1981, c. 275, s. 1; 1995, c. 508, s. 2; 1997-443, s. 11A.118(a).)

**§ 108A-60. Protection of patient property.**

(a) It shall be unlawful for any person:

(1) To willfully commingle or cause or solicit the commingling of the personal funds or moneys of a recipient resident of a provider health care facility with the funds or moneys of such facility; or

(2) To willfully embezzle, convert, or appropriate or cause or solicit the embezzlement, conversion or appropriation of recipient personal funds or property to his own use or to the use of any provider or other person or entity.

(b) A violation of subdivision (a)(1) of this section shall be a Class 1 misdemeanor. A violation of subdivision (a)(2) of this section shall be a Class H felony.

(c) For purposes of this section:

(1) "Health care facility" shall include skilled nursing facilities, intermediate care facilities, rest homes, or any other residential health care facility; and

(2) "Person" includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity or organization; and

(3) "Recipient" shall include current resident recipients, deceased recipients and recipients who no longer reside at such facility. (1979, c. 510, s. 1; 1981, c. 275, s. 1; 1993, c. 539, ss. 816, 1300; 1994, Ex. Sess., c. 24, s. 14(c).)

**§ 108A-61: Repealed by Session Laws 1989, c. 701.**

**§ 108A-61.1. Financial responsibility of a parent for a child under age 21 in a medical institution.**

Notwithstanding any other provisions of the law, for the purpose of determining eligibility for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., the income and financial resources of the natural or adoptive parents of a person who is under the age of 21 and who requires Medicaid covered services in a medical institution shall not be counted if the patient's physician certifies, and the Division of Health Benefits or its agents approve, that continuous care and treatment are expected to exceed 12 months. For purposes of this subsection, "medical institution" means licensed acute care inpatient medical facilities providing medical, surgical, and psychiatric or substance abuse treatment, or facilities providing skilled or intermediate care, including intermediate care for individuals with intellectual disabilities. (1993, c. 386, s. 1; 2019-81, s. 15(a); 2021-62, s. 4.1; 2021-88, s. 9(c).)

**§ 108A-62. Therapeutic leave for medical assistance patients.**

(a) A medical assistance beneficiary at an intermediate care facility or skilled nursing facility may take therapeutic leave in accordance with this section without the facility losing reimbursement under the medical assistance program.

(b) The maximum amount of therapeutic leave days that may be taken in a calendar year by a medical assistance beneficiary are as follows:

(1) Ninety days for a beneficiary in an intermediate care facility.

(2) Sixty days for a beneficiary in a skilled nursing facility.

(c) No more than 15 consecutive days of therapeutic leave may be taken by a medical assistance beneficiary without the approval of one of the following:

(1) The Division of Health Benefits of the Department.

(2) The local management entity/managed care organization with which the beneficiary is enrolled under Chapter 122C of the General Statutes.

(3) The prepaid health plan with which the beneficiary is enrolled under Chapter 108D of the General Statutes. (1979, c. 925; 1981, c. 275, s. 1; 1985 (Reg. Sess., 1986), c. 1014, s. 120; 1991, c. 126, s. 1; 1997-443, s. 11A.118(a); 2019-81, s. 15(a); 2021-62, s. 3.1(a).)

**§ 108A-63. Medical assistance provider fraud.**

(a) It shall be unlawful for any provider of medical assistance under this Part to knowingly and willfully make or cause to be made any false statement or representation of a material fact:

(1) In any application for payment under this Part, or for use in determining entitlement to such payment; or

(2) With respect to the conditions or operation of a provider or facility in order that such provider or facility may qualify or remain qualified to provide assistance under this Part.

(b) It shall be unlawful for any provider of medical assistance to knowingly and willfully conceal or fail to disclose any fact or event affecting:

(1) His initial or continued entitlement to payment under this Part; or

(2) The amount of payment to which such person is or may be entitled.

(c) Except as otherwise provided in subsection (e) of this section, any person who violates a provision of this section shall be guilty of a Class I felony.

(d) "Provider" shall include any person who provides goods or services under this Part and any other person acting as an employee, representative or agent of such person.

(e) In connection with the delivery of or payment for benefits, items, or services under this Part, it shall be unlawful for any provider of medical assistance under this Part to knowingly and willfully execute, or attempt to execute, a scheme or artifice to:

(1) Defraud the Medical Assistance Program.

(2) Obtain, by means of false or fraudulent pretenses, representations, or promises of material fact, any of the money or property owned by, or under the custody or control of, the Medical Assistance Program.

A violation of this subsection is a Class H felony. A conspiracy to violate this subsection is a Class I felony.

(f) It shall be unlawful for any provider, with the intent to obstruct, delay, or mislead an investigation of a violation of this section by the Attorney General's office, to knowingly and willfully make or cause to be made a false entry in, alter, destroy, or conceal, or make a false statement about a financial, medical, or other record related to the provision of a benefit, item, or service under this Part.

(g) It shall be unlawful for any person to knowingly and willfully solicit or receive any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in-kind:

(1) In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this Part.

(2) In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this Part.

(h) It shall be unlawful for any person to knowingly and willfully offer or pay any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in-kind to any person to induce such person:

(1) To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this Part.

(2) To purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this Part.

(i) Subsections (g) and (h) of this section shall not apply to:

(1) Contracts between the State and a public or private agency where part of the agency's responsibility is referral of a person to a provider.

(2) Any conduct or activity that is specified in 42 U.S.C. § 1320a-7b(b)(3), as amended, or any federal regulations adopted pursuant thereto.

(j) Nothing in subsections (g) and (h) of this section shall be interpreted or construed to conflict with 42 U.S.C. § 1320a-7b(b), as amended, or with federal common law or federal agency interpretations of the statute. (1979, c. 510, s. 1; 1981, c. 275, s. 1; 2009-554, s. 3; 2010-185, s. 1.)

**§ 108A-63.1. Health care fraud subpoena to produce documents.**

(a) The Attorney General, acting through the Medicaid Investigations Unit of the Department of Justice, may, when engaged in an investigation of an alleged violation of G.S. 108A-63 and prior to the arrest of a suspect, issue in writing and cause to be served a subpoena to produce documents upon any corporation or governmental entity requiring the production of any records, books, papers, electronic media, objects, or other documents which may be relevant to a criminal investigation of a violation of G.S. 108A-63.

(b) A subpoena under this section may require the custodian of records of the corporation or governmental entity to produce an affidavit certifying that the custodian made a thorough and diligent search for the documents requested and that the documents produced constitute all the records requested to the best of the custodian's knowledge, information, and belief.

(c) A subpoena under this section shall describe the documents required to be produced and prescribe a return date within a reasonable period of time, of no less than 20 days from the date of service, within which the documents can be assembled and made available.

(d) A corporation or governmental entity may comply with a subpoena issued under this section by delivering the documents to the Medicaid Investigations Unit by any of the following methods:

(1) By hand delivery.
(2) By mailing the documents by certified mail.
(3) By making the documents reasonably available for transfer to an agent of the Medicaid Investigations Unit at a place of business of the corporation or governmental entity.
(4) If agreed to by the Medicaid Investigations Unit and the corporation or governmental entity, by any other means.

(e) A corporation or governmental entity may move to quash or modify a subpoena issued under this section if it is oppressive or unreasonable or does not comply with the requirements of this section. The motion must be made before the time specified in the subpoena for production and may be made before a judge of the superior court.

(f) In the case of failure by any corporation or governmental entity without adequate excuse to obey a subpoena issued under this section, the Attorney General may invoke the aid of a judge of the superior court. The court may issue an order requiring the subpoenaed corporation or governmental entity to appear before the Attorney General to produce records. Failure to obey the order of the court may be punished as contempt of court. (2009-554, s. 2.)

**§ 108A-64. Medical assistance recipient fraud.**

(a) It shall be unlawful for any person to knowingly and willfully and with intent to defraud make or cause to be made a false statement or representation of a material fact in an application for assistance under this Part, or intended for use in determining entitlement to such assistance.

(b) It shall be unlawful for any applicant, recipient or person acting on behalf of such applicant or recipient to knowingly and willfully and with intent to defraud, conceal or fail to disclose any condition, fact or event affecting such applicant's or recipient's initial or continued entitlement to receive assistance under this Part.

(b1) It is unlawful for any person knowingly, willingly, and with intent to defraud, to obtain or attempt to obtain, or to assist, aid, or abet another person, either directly or indirectly, to obtain money, services, or any other thing of value to which the person is not entitled as a recipient under this Part, or otherwise to deliberately misuse a Medicaid identification card. This misuse includes

the sale, alteration, or lending of the Medicaid identification card to others for services and the use of the card by someone other than the recipient to receive or attempt to receive Medicaid program coverage for services rendered to that individual.

Proof of intent to defraud does not require proof of intent to defraud any particular person.

(c) (1) A person who violates a provision of this section shall be guilty of a Class I felony if the value of the assistance wrongfully obtained is more than four hundred dollars ($400.00).

(2) A person who violates a provision of this section shall be guilty of a Class 1 misdemeanor if the value of the assistance wrongfully obtained is four hundred dollars ($400.00) or less.

(d) For purposes of this section the word "person" includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity or organization. (1981, c. 275, s. 1; 1993, c. 539, s. 817; 1994, Ex. Sess., c. 24, s. 14(c); 1995, c. 317, s. 1.)

**§ 108A-64.1. Incentives to counties to recover fraudulent Medicaid expenditures.**

The Department of Health and Human Services, Division of Health Benefits, shall provide incentives to counties that successfully recover fraudulently spent Medicaid funds by sharing State savings with counties responsible for the recovery of the fraudulently spent funds. (2013-360, s. 12H.5; 2019-81, s. 15(a).)

**§ 108A-65. Conflict of interest.**

(a) It shall be unlawful for any person who is or has been an officer or employee of State or county government, and as such is or has been responsible for the expenditure of substantial amounts of federal, State or county money under the State medical assistance plan, or any person who is the partner of the present or former officer or employee, to engage in any of the following activities relating to the State medical assistance program:

(1) Knowingly to act as agent or attorney for, or otherwise knowingly to represent, any person other than the United States, the State or a county, in any formal or informal appearance before, or with the intent to influence, make any oral or written communication on behalf of any other person other than the United States, the State or a county to:

a. Any department, agency, court, board, commission, legislature or committee of the United States, the State or a county, or any officer or employee thereof,

b. In connection with any of the following matters in which the United States, the State, or a county is a party or has a direct and substantial interest, such as any judicial or other proceeding, legislation, application, request for a ruling or other determination, contract, claim, controversy, investigation, charge, accusation, arrest, or other particular matter involving a specific party or parties,

c. In which he participated personally and substantially as an officer or an employee through decision, approval, recommendation, the rendering of advice, investigation or otherwise.

(2) Within two years after his employment has ceased, knowingly to act as agent or attorney for, or otherwise knowingly to represent, any other person other than the United States, the State or a county, in any formal or informal appearance

before, or, with the intent to influence, make any oral or written communication on behalf of any other person other than the United States, the State or a county to:

a. Any department, agency, court, board, commission, legislature or committee of the United States, the State, or a county, or any officer or employee thereof,

b. In connection with any of the following matters in which the United States, the State, or a county is a party or has a direct and substantial interest, such as, any judicial or other proceeding, legislation, application, request for a ruling or other determination, contract, claim, controversy, investigation, charge, accusation, arrest, or other particular matter involving a specific party or parties,

c. Which was actually pending under his official responsibility as an officer or employee within a period of one year prior to the termination of responsibility.

(3) Within two years after his employment has ceased, knowingly to aid, counsel, advise, consult or by personal presence represent any other person other than the United States, the State or a county in any formal or informal appearance before:

a. Any department, agency, court, board, commission, legislature or committee of the United States, the State, or the county, or any officer or employee thereof,

b. In connection with any of the following matters in which the United States, the State, or a county is a party or has a direct and substantial interest, such as, any judicial or other proceeding, legislation, application, request for a ruling or other determination, contract, claim, controversy, investigation, charge, accusation, arrest, or other particular matter involving a specific party or parties,

c. Which was actually pending under his official responsibility as an officer or employee within the period of one year prior to the termination of such responsibility.

(4) To participate personally and substantially as an officer or employee, through decision, approval, disapproval, recommendation, rendering of advice, investigation or otherwise, in a judicial or other proceeding legislation, application, request for a ruling or other determination, contract, claim, controversy, charge, accusation, arrest or other particular matter in which, to his knowledge, he, his spouse, minor child, partner, organization in which he is serving as an officer, director, trustee, partner or employee, or any person or organization with whom he is negotiating or has any arrangement concerning prospective employment, has a financial interest.

(b) Violation of this statute is a Class 1 misdemeanor.

(c) The Department of Health and Human Services shall annually identify and designate by rule or regulation those positions which are filled by State or county officers or employees who are responsible for the expenditure of substantial amounts of moneys under the State medical assistance plan. (1981, c. 679, s. 1; 1993, c. 539, s. 818; 1994, Ex. Sess., c. 24, s. 14(c); 1997-443, s. 11A.118(a).)

**§ 108A-66: Repealed by Session Laws 1989, c. 702.**

**§ 108A-66.1. Medicaid buy-in for workers with disabilities.**

(a) Title. – This section may be cited as the Health Coverage for Workers With Disabilities Act. The Department shall implement a Medicaid buy-in eligibility category as permitted under P.L. 106-170, Ticket to Work and Work Incentives Improvement Act of 1999. The Department shall establish rules, policies, and procedures to implement this act in accordance with this section.

(b) Definitions. – As used in this section, unless the context clearly requires otherwise:

(1) "FPG" means the federal poverty guidelines.

(2) "HCWD" means Health Coverage for Workers With Disabilities.

(3) "SSI" means Supplemental Security Income.

(4) "Ticket to Work" means the Ticket to Work and Work Incentives Improvement Act of 1999.

(c) Eligibility. – An individual is eligible for HCWD if:

(1) The individual is at least 16 years of age and is less than 65 years of age;

(2) The individual meets Social Security Disability criteria, or the individual has been enrolled in HCWD and then becomes medically improved as defined in Ticket to Work and as further specified by the Department. An individual shall be determined to be eligible under this section without regard to the individual's ability to engage in, or actual engagement in, substantial gainful activity as defined in section 223 of the Social Security Act (42 U.S.C. § 423(d)(4)). In conducting annual redetermination of eligibility, the Department may not determine that an individual participating in HCWD is no longer disabled based solely on the individual's participation in employment or earned income;

(3) The individual's unearned income does not exceed one hundred fifty percent (150%) of FPG, and countable resources for the individual do not exceed the resource limit for the minimum community spouse resource standard under 42 U.S.C. § 1396r, and as further determined by the Department. In determining an individual's countable income and resources, the Department may not consider income or resources that are disregarded under the State Medical Assistance Plan's financial methodology, including the sixty-five-dollar ($65.00) disregard, impairment-related work expenses, student earned-income exclusions, and other SSI program work incentive income disregards; and

(4) The individual is engaged in a substantial and reasonable work effort (employed) as provided in this subdivision and as further defined by the Department and allowable under federal law. For purposes of this subsection, "engaged in substantial and reasonable work effort" means all of the following:

a. Working in a competitive, inclusive work setting, or self-employed.

b. Earning at least the applicable minimum wage.

c. Having monthly earnings above the SSI basic sixty-five-dollar ($65.00) earned-income disregard.

d. Being able to provide evidence of paying applicable Medicare, Social Security, and State and federal income taxes.

The Department may impose additional earnings requirements in defining "engaged in substantial and reasonable work effort" for individuals who are eligible for HCWD based on medical improvement.

Individuals who participate in HCWD but thereafter become unemployed for involuntary reasons, including health reasons, shall have continued eligibility in HCWD for up to 12 months from the time of involuntary unemployment, so long as the individual (i) maintains a connection with the workforce, as determined by the Department, (ii) meets all other eligibility criteria for HCWD during the period, and (iii) pays applicable fees, premiums, and co-payments.

(d) Fees, Premiums, and Co-Payments. – Individuals who participate in HCWD and have countable income greater than one hundred fifty percent (150%) of FPG shall pay an annual enrollment fee of fifty dollars ($50.00) to their county department of social services. Individuals who participate in HCWD and have countable income greater than or equal to two hundred percent (200%) of FPG shall pay a monthly premium in addition to the annual fee. The Department shall set a sliding scale for premiums, which is consistent with applicable federal law. An individual with countable income equal to or greater than four hundred fifty percent (450%) of FPG shall pay not less than one hundred percent (100%) of the cost of the premium, as determined by the Department. The premium shall be based on the experience of all individuals participating in the Medical Assistance Program. Individuals who participate in HCWD are subject to co-payments equal to those required under the Medical Assistance Program. (2005-276, s. 10.18(a); 2006-66, s. 10.9(a); 2007-144, s. 2; 2009-451, s. 10.69; 2013-360, s. 12H.10(f).)

**§ 108A-67. Medicare/Qualified Disabled Working Individuals.**

Qualified disabled working individuals are eligible for the payment of the Medicare Part A premium. An individual is qualified for this payment:

(1) If the Social Security Administration determines the individual to be a "Disabled Working Individual";

(2) If the individual's income is less than two hundred percent (200%) of the current federal poverty level, as revised annually; and

(3) If the individual is less than 65 years of age. (1991, c. 127.)

**§ 108A-68. Drug Use Review Program; rules.**

Notwithstanding the provisions of Chapter 90 of the General Statutes or of any other provision of law, the Division of Health Benefits, Department of Health and Human Services, shall adopt rules implementing the drug use review provisions of the Omnibus Budget Reconciliation Act of 1990, as amended. (1991 (Reg. Sess., 1992), c. 900, s. 128; 1997-443, s. 11A.118(a); 2019-81, s. 15(a).)

**§ 108A-68.1. Certain prescription drugs exempt from prior authorization requirements.**

Prior authorization shall not be required or utilized for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available. Nothing in this section shall prohibit the Secretary from implementing a disease management program. (2003-179, s. 1; 2005-83, s. 1; 2009-210, s. 1.)

**§ 108A-68.2. (Effective until contingency met – see note) Beneficiary lock-in program for certain controlled substances.**

(a) The following definitions apply in this section:

(1) Covered substances. – Any controlled substance identified as an opioid or benzodiazepine, excluding benzodiazepine sedative-hypnotics, contained in Article 5 of Chapter 90 of the General Statutes, unless one of the following conditions are met:

a. If the Department of Health and Human Services specifically identifies the opioid or benzodiazepine as a substance excluded from coverage by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the opioid or benzodiazepine is not a covered substance under this section.

b. If the Department of Health and Human Services specifically identifies a controlled substance contained in Article 5 of Chapter 90 of the General Statutes other than an opioid or benzodiazepine as a controlled substance covered by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the controlled substance is a covered substance under this section.

(2) Lock-in program. – A requirement that a Medicaid or NC Health Choice beneficiary select a single prescriber and a single pharmacy for obtaining covered substances.

(3) Prepaid health plan or PHP. – As defined in G.S. 108D-1.

(b), (c) Repealed by Session Laws 2021-62, s. 4.4, effective June 29, 2021.

(d) This section does not apply to any lock-in program for Medicaid or NC Health Choice beneficiaries who are not enrolled in a Prepaid Health Plan.

(e) A Prepaid Health Plan may develop a lock-in program for Medicaid or NC Health Choice beneficiaries who meet any of the following criteria:

(1) Have filled six or more prescriptions for covered substances in a period of two consecutive months.

(2) Have received prescriptions for covered substances from three or more providers in a period of two consecutive months.

(3) Are recommended as a candidate for the lock-in program by a provider.

(f) A lock-in program developed pursuant to subsection (e) of this section shall comply with all of the following:

(1) A beneficiary shall not be subject to the lock-in program until the Prepaid Health Plan has notified the beneficiary in writing that the beneficiary will be subject to the lock-in program.

(2) A beneficiary subject to the lock-in program shall be given the opportunity to select a single prescriber and a single pharmacy from a list of prescribers and pharmacies in the Prepaid Health Plan's provider network. For any beneficiary who fails to select a single prescriber, the Prepaid Health Plan shall use algorithmic guidelines to assign the beneficiary a single prescriber from a list of prescribers in the Prepaid Health Plan's network. For any beneficiary who fails to select a single pharmacy, the Prepaid Health Plan shall use algorithmic

guidelines to assign the beneficiary a single pharmacy from a list of pharmacies in the Prepaid Health Plan's network.

(3) A beneficiary shall not be required to use the single prescriber or single pharmacy selected for the lock-in program to obtain prescriptions drugs covered by the Medicaid program or the Prepaid Health Plan that are not covered substances.

(g) A Prepaid Health Plan's use of a lock-in program developed pursuant to subsection (e) of this section shall not constitute a violation of the terms of a contract between the Prepaid Health Plan and the Department that relate to a beneficiary's ability to utilize a pharmacy of choice. (2018-49, s. 3(a); 2021-62, s. 4.4.)

**§ 108A-68.2. (Effective once contingency met – see note) Beneficiary lock-in program for certain controlled substances.**

(a) The following definitions apply in this section:

(1) Covered substances. – Any controlled substance identified as an opioid or benzodiazepine, excluding benzodiazepine sedative-hypnotics, contained in Article 5 of Chapter 90 of the General Statutes, unless one of the following conditions are met:

a. If the Department of Health and Human Services specifically identifies the opioid or benzodiazepine as a substance excluded from coverage by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the opioid or benzodiazepine is not a covered substance under this section.

b. If the Department of Health and Human Services specifically identifies a controlled substance contained in Article 5 of Chapter 90 of the General Statutes other than an opioid or benzodiazepine as a controlled substance covered by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the controlled substance is a covered substance under this section.

(2) Lock-in program. – A requirement that a Medicaid beneficiary select a single prescriber and a single pharmacy for obtaining covered substances.

(3) Prepaid health plan or PHP. – As defined in G.S. 108D-1.

(b), (c) Repealed by Session Laws 2021-62, s. 4.4, effective June 29, 2021.

(d) This section does not apply to any lock-in program for Medicaid beneficiaries who are not enrolled in a Prepaid Health Plan.

(e) A Prepaid Health Plan may develop a lock-in program for Medicaid beneficiaries who meet any of the following criteria:

(1) Have filled six or more prescriptions for covered substances in a period of two consecutive months.

(2) Have received prescriptions for covered substances from three or more providers in a period of two consecutive months.

(3) Are recommended as a candidate for the lock-in program by a provider.

(f) A lock-in program developed pursuant to subsection (e) of this section shall comply with all of the following:

(1) A beneficiary shall not be subject to the lock-in program until the Prepaid Health Plan has notified the beneficiary in writing that the beneficiary will be subject to the lock-in program.

(2) A beneficiary subject to the lock-in program shall be given the opportunity to select a single prescriber and a single pharmacy from a list of prescribers and pharmacies in the Prepaid Health Plan's provider network. For any beneficiary who fails to select a single prescriber, the Prepaid Health Plan shall use algorithmic guidelines to assign the beneficiary a single prescriber from a list of prescribers in the Prepaid Health Plan's network. For any beneficiary who fails to select a single pharmacy, the Prepaid Health Plan shall use algorithmic guidelines to assign the beneficiary a single pharmacy from a list of pharmacies in the Prepaid Health Plan's network.

(3) A beneficiary shall not be required to use the single prescriber or single pharmacy selected for the lock-in program to obtain prescriptions drugs covered by the Medicaid program or the Prepaid Health Plan that are not covered substances.

(g) A Prepaid Health Plan's use of a lock-in program developed pursuant to subsection (e) of this section shall not constitute a violation of the terms of a contract between the Prepaid Health Plan and the Department that relate to a beneficiary's ability to utilize a pharmacy of choice. (2018-49, s. 3(a); 2021-62, s. 4.4; 2022-74, s. 9D.15(z).)

**§ 108A-69. Employer obligations.**

(a) As used in this section and in G.S. 108A-70:

(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; the State Health Plan for Teachers and State Employees under Chapter 135 of the General Statutes; or a plan provided by another benefit arrangement. "Health benefit plan" does not mean a Medicare supplement policy as defined in G.S. 58-54-1(5).

(2) "Health insurer" means any health insurance company subject to Articles 1 through 63 of Chapter 58 of the General Statutes, including a multiple employee welfare arrangement, and any corporation subject to Articles 65 and 67 of Chapter 58 of the General Statutes; a group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974; and the State Health Plan for Teachers and State Employees under Chapter 135 of the General Statutes.

(b) If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through an employer, the employer:

(1) Must allow the parent to enroll, under family coverage, the child if the child would be otherwise eligible for coverage without regard to any enrollment season restrictions.

(2) Must enroll the child under family coverage upon application of the child's other parent or upon receipt of notice from the Department of Health and Human Services in connection with its administration of the Medical Assistance or

Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

(3) May not disenroll or eliminate coverage of the child unless:

a. The employer is provided satisfactory written evidence that:

1. The court or administrative order is no longer in effect; or

2. The child is or will be enrolled in comparable health benefit plan coverage that will take effect not later than the effective date of disenrollment; or

b. The employer has eliminated family health benefit plan coverage for all of its employees.

(4) Must withhold from the employee's compensation the employee's share, if any, of premiums for health benefit plan coverage, not to exceed the maximum amount permitted to be withheld under section 303(b) of the federal Consumer Credit Protection Act, as amended; and must pay this amount to the health insurer; subject to regulations, if any, adopted by the Secretary of the U.S. Department of Health and Human Services. (1993 (Reg. Sess., 1994), c. 644, s. 3; 1995, c. 193, s. 44; 1997-433, s. 3.2; 1997-443, s. 11A.118(a); 1998-17, s. 1; 1999-293, s. 8; 2007-323, s. 28.22A(o); 2007-345, s. 12.)

**§ 108A-70. Recoupment of amounts spent on medical care.**

(a) To the extent necessary to reimburse the Department or a PHP for expenditures for costs under this Part, and provided that claims for current and past due child support shall take priority over claims for those expenditures, the Department may garnish the wages, salary, or other employment income of, and the Secretary of Revenue shall withhold amounts from State tax refunds to, any person who meets all of the following criteria:

(1) Is required by court or administrative order to provide health benefit plan coverage for the cost of health care services to a child eligible for medical assistance under Medicaid.

(2) Has received payment from a third party for the costs of such services.

(3) Has not used such payments to reimburse, as appropriate, either the other parent or guardian of the child or the provider of the services.

(b) To the extent that payment for covered services has been made under G.S. 108A-55 for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the Department of Health and Human Services is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. (1993 (Reg. Sess., 1994), c. 644, s. 3; 1997-443, s. 11A.118(a); 2019-81, s. 5.)

**§ 108A-70.4. Long-Term Care Partnership Program.**

(a) The following definitions apply in this section:

(1) Asset. – Resources and income.

(2) Department. – The Department of Health and Human Services.

(3) Division. – The Division of Health Benefits.

(4) Estate recovery. – The placing of a statutory claim on the estate of a deceased Medicaid recipient, as provided by G.S. 108A-70.5.

(5) Medicaid. – The federal medical assistance program established under Title XIX of the Social Security Act.

(6) Qualified long-term care partnership policy or qualified policy. – A long-term care insurance policy approved for use in North Carolina and that meets all the requirements of the federal Deficit Reduction Act of 2005, P.L. 109-171.

(7) Resource. – Cash or its equivalent and real or personal property that is available to an applicant or recipient.

(8) Resource disregard. – The amount of resources of an applicant for long-term care Medicaid that is equal to the amount of benefits paid to the applicant under a qualified long-term care partnership policy.

(9) Resource protection. – An amount equal to the resource disregard given to a Medicaid recipient during the long-term care Medicaid eligibility determination process.

(b) There is established the North Carolina Long-Term Care Partnership Program (Partnership Program) to be administered by the Division with assistance from the Department of Insurance. The Partnership Program shall:

(1) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

(2) Provide counseling services to individuals planning for their long-term care needs.

(3) Reduce the financial burden on the State medical assistance program by encouraging individuals to obtain private long-term care insurance.

(c) Under the Partnership Program, the Department shall:

(1) Provide resource disregard to an applicant for long-term care Medicaid who has received benefits under a qualified long-term care partnership policy. The amount of the resource disregard shall be equal to the total insurance benefits paid to the individual under a qualified policy after the implementation of the Partnership Program and prior to the individual's first application for long-term care Medicaid.

(2) Provide resource protection by reducing any subsequent recovery by the State under G.S. 108A-70.5 from a deceased recipient's estate for payment of Medicaid paid services by the amount of resource disregard given under subdivision (1) of this subsection.

(d) The Department shall adopt rules and amendments to the State Plan to allow for resource disregard at long-term care Medicaid eligibility determination and resource protection at estate recovery. The Department and the Department of Insurance shall adopt rules to implement the provisions of the Partnership Program and to provide for its administration.

(e) Effective January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later, a qualified long-term care partnership policy shall be accompanied by a Partnership Disclosure Notice detailing in plain language the current law pertaining to the Partnership Program, resource disregard, and resource protection.

(f) The Department may enter into a reciprocal agreement with other states that enter into a national reciprocity agreement to extend the resource disregard and resource protection to residents of the State who purchased, or purchased and used, a qualified long-term care policy in another state.

(g) G.S. 108A-70.5 applies to the estate of an individual who received benefits under a qualified long-term care partnership policy. (2010-68, s. 1; 2019-81, s. 15(a).)

**§ 108A-70.5. Medicaid Estate Recovery Plan.**

(a) There is established in the Department of Health and Human Services, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid for the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 U.S.C. § 1396(p).

(b) The following definitions apply in this section:

(1) Recodified as subdivision (b)(4) of this section by Session Laws 2021-88, s. 9(d).

(2) Estate. – All the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1. The Department has all rights available to estate creditors, including the right to qualify as personal representative or collector of an estate. For individuals who have received benefits under a qualified long-term care partnership policy as described in G.S. 108A-70.4, this term also includes any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of the interest), including assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(3) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(4) Medical assistance. – Medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient as follows:

a. If the recipient of any age is receiving medical care services as an inpatient in a nursing facility, intermediate care facility for individuals with intellectual disabilities, or other medical institution, and cannot reasonably be expected to be discharged to return home.

b. If the recipient is 55 years of age or older and is receiving one or more of the following medical care services:

1. Nursing facility services.
2. Home and community-based services.
3. Hospital care.
4. Prescription drugs.
5. Personal care services.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and is recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a sixth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate; however, judgments in favor of other sixth-class creditors docketed and in force before the Department seeks recovery for medical assistance shall be paid prior to recovery by the Department.

(d) The Department of Health and Human Services shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are

notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(f) With regard to any recipient who has received compensation pursuant to Part 30 of Article 9 of Chapter 143B of the General Statutes, the Department shall reduce the amount of any recovery it seeks from the deceased recipient's estate under this section by the amount of the resource disregard provided for in G.S. 143B-426.56(b)(1). (1993 (Reg. Sess., 1994), c. 769, s. 25.47(a); 1997-443, s. 11A.118(a); 2002-126, s. 10.11(b); 2005-276, s. 10.21C(a); 2005-345, s. 16; 2006-66, s. 10.9B; 2007-145, s. 10; 2007-323, ss. 10.42(a), (b); 2007-442, s. 1(a); 2010-68, s. 2; 2012-18, s. 3.6; 2013-378, s. 2; 2014-100, s. 6.13(f); 2021-62, s. 4.1; 2021-88, s. 9(d), (e).)

**§ 108A-70.6:** Repealed by Session Laws 2007-442, s. 1(b), effective August 23, 2007.

**§ 108A-70.7:** Repealed by Session Laws 2007-442, s. 1(b), effective August 23, 2007.

**§ 108A-70.8:** Repealed by Session Laws 2007-442, s. 1(b), effective August 23, 2007.

**§ 108A-70.9:** Repealed by Session Laws 2007-442, s. 1(b), effective August 23, 2007.

Part 6A. Appeals Process for Certain Medicaid and NC Health Choice Determinations.

**§ 108A-70.9A. (Effective until contingency met – see note) Definitions; Medicaid recipient appeals.**

(a) Definitions. – The following definitions apply in this Part:

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid service through the fee-for-service program. An adverse benefit determination as defined in G.S. 108D-1 is not an adverse determination for purposes of this Part.

(1a) Adverse disenrollment decision. – As defined in G.S. 108D-1.

(1b) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient appealing an adverse determination under this Part or (ii) a Medicaid or a NC Health Choice recipient appealing an adverse disenrollment determination under G.S. 108D-5.9.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) Medicaid Recipient Appeals. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the Department and the process used by a Medicaid or NC Health Choice recipient to appeal an adverse disenrollment determination by the Department.

(c) Notice. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of an adverse determination, the Department shall notify the recipient, and the provider, if applicable, in writing of the adverse determination and of the recipient's right to appeal the adverse determination. The Department shall not be required to notify a recipient's parent, guardian, or legal representative unless the recipient's parent, guardian, or legal

representative has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

(1) An identification of the recipient whose services are being affected by the adverse determination, including the recipient's full name and Medicaid identification number.
(2) An explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.
(3) The specific regulation, statute, or medical policy that supports or requires the adverse determination.
(4) The effective date of the adverse determination.
(5) An explanation of the recipient's right to appeal the Department's adverse determination in an evidentiary hearing before an administrative law judge.
(6) An explanation of how the recipient can request a hearing and a statement that the recipient may represent himself or herself or use legal counsel, a relative, or other spokesperson.
(7) A statement that the recipient will continue to receive Medicaid services at the level provided on the day immediately preceding the Department's adverse determination or the amount requested by the recipient, whichever is less, if the recipient requests a hearing before the effective date of the adverse determination. The services shall continue until the hearing is completed and a final decision is rendered.
(8) The name and telephone number of a contact person at the Department to respond in a timely fashion to the recipient's questions.
(9) The telephone number by which the recipient may contact a Legal Aid/Legal Services office.
(10) The appeal request form described in subsection (e) of this section that the recipient may use to request a hearing.

(c1) Notice Availability. – The Department shall make available to OAH a copy of the notice of adverse determination required under subsection (c) of this section. The information contained in the notice is confidential unless the recipient appeals the adverse determination under subsection (d) of this section. OAH may dispose of these records after one year.

(d) Appeals. – Except as provided by this section and G.S. 108A-70.9B, a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The recipient shall request a hearing within 30 days of the mailing of the notice required by subsection (c) of this section by filing an appeal request with OAH. Where a request for hearing concerns the reduction, modification, or termination of Medicaid services, including the failure to act upon a timely request for reauthorization with reasonable promptness, upon the receipt of a timely appeal, the Department shall reinstate the services to the level or manner prior to action by the Department as permitted by federal law or regulation. The Department may not influence, limit, or interfere with the recipient's decision to request a hearing.

(e) Appeal Request Form. – Along with the notice required by subsection (c) of this section, the Department shall also provide the recipient with an appeal request form which shall be no more than one side of one page. The form shall include the following:

(1) A statement that, in order to request an appeal, the recipient must file the form with OAH within 30 days of mailing of the notice, and the form may be filed

by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form.

(2) The recipient's name, address, telephone number, and Medicaid identification number.

(3) A preprinted statement that indicates that the recipient would like to appeal the specific adverse determination of which the recipient was notified in the notice.

(3a) The option for the recipient to request an expedited appeal.

(4) A statement informing the recipient that he or she may choose to be represented by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the recipient's signature and date.

(e1) Expedited Appeal Request. – In accordance with 42 C.F.R. § 431.224, a recipient may request that an appeal under subsection (d) of this section be expedited if the time otherwise permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain, or regain maximum function. With regard to a request for an expedited appeal, all of the following apply:

(1) The recipient shall submit any additional documentation from a licensed health care professional with relevant excerpts from the recipient's medical record that was not already provided with regard to the adverse determination to demonstrate the need for an expedited appeal.

(2) The Department shall determine if the recipient's request meets the criteria for an expedited appeal.

(3) If the Department determines that the recipient's request does not meet the criteria for an expedited appeal, then (i) the Department shall make reasonable efforts to give the recipient, or the recipient's parent, guardian, or legal representative, oral notice of the denial as expeditiously as possible and shall follow up with a written notice of denial and (ii) the recipient's appeal shall not be subject to the expedited time frame in subdivision (4) of this subsection. The denial is not appealable.

(4) If the Department determines that the recipient's request meets the criteria for an expedited appeal, then (i) the mediation procedure under G.S. 108A-70.9B(c) shall not apply to the appeal request and (ii) the decision required under G.S. 108A-70.9B(g) shall be made as expeditiously as possible.

(f) Final Decision. – After a hearing before an administrative law judge, the judge shall return the decision to the Department in accordance with G.S. 150B-37. The Department shall notify the recipient of the final decision and of the right to judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes. (2010-31, s. 10.30(a); 2011-398, s. 32; 2019-81, s. 6; 2021-62, ss. 2.1(a)-(c), 2.2(a), (b).)

**§ 108A-70.9A. (Effective once contingency met – see note) Definitions; Medicaid recipient appeals.**

(a) Definitions. – The following definitions apply in this Part:

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid service through the fee-for-service program. An adverse benefit

determination as defined in G.S. 108D-1 is not an adverse determination for purposes of this Part.

(1a) Adverse disenrollment decision. – As defined in G.S. 108D-1.

(1b) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient appealing an adverse determination under this Part or (ii) a Medicaid recipient appealing an adverse disenrollment determination under G.S. 108D-5.9.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) Medicaid Recipient Appeals. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the Department and the process used by a Medicaid recipient to appeal an adverse disenrollment determination by the Department.

(c) Notice. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of an adverse determination, the Department shall notify the recipient, and the provider, if applicable, in writing of the adverse determination and of the recipient's right to appeal the adverse determination. The Department shall not be required to notify a recipient's parent, guardian, or legal representative unless the recipient's parent, guardian, or legal representative has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

(1) An identification of the recipient whose services are being affected by the adverse determination, including the recipient's full name and Medicaid identification number.

(2) An explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.

(3) The specific regulation, statute, or medical policy that supports or requires the adverse determination.

(4) The effective date of the adverse determination.

(5) An explanation of the recipient's right to appeal the Department's adverse determination in an evidentiary hearing before an administrative law judge.

(6) An explanation of how the recipient can request a hearing and a statement that the recipient may represent himself or herself or use legal counsel, a relative, or other spokesperson.

(7) A statement that the recipient will continue to receive Medicaid services at the level provided on the day immediately preceding the Department's adverse determination or the amount requested by the recipient, whichever is less, if the recipient requests a hearing before the effective date of the adverse determination. The services shall continue until the hearing is completed and a final decision is rendered.

(8) The name and telephone number of a contact person at the Department to respond in a timely fashion to the recipient's questions.

(9) The telephone number by which the recipient may contact a Legal Aid/Legal Services office.

(10) The appeal request form described in subsection (e) of this section that the recipient may use to request a hearing.

(c1) Notice Availability. – The Department shall make available to OAH a copy of the notice of adverse determination required under subsection (c) of this section. The information contained in the notice is confidential unless the recipient appeals the adverse determination under subsection (d) of this section. OAH may dispose of these records after one year.

(d) Appeals. – Except as provided by this section and G.S. 108A-70.9B, a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The recipient shall request a hearing within 30 days of the mailing of the notice required by subsection (c) of this section by filing an appeal request with OAH. Where a request for hearing concerns the reduction, modification, or termination of Medicaid services, including the failure to act upon a timely request for reauthorization with reasonable promptness, upon the receipt of a timely appeal, the Department shall reinstate the services to the level or manner prior to action by the Department as permitted by federal law or regulation. The Department may not influence, limit, or interfere with the recipient's decision to request a hearing.

(e) Appeal Request Form. – Along with the notice required by subsection (c) of this section, the Department shall also provide the recipient with an appeal request form which shall be no more than one side of one page. The form shall include the following:

(1) A statement that, in order to request an appeal, the recipient must file the form with OAH within 30 days of mailing of the notice, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form.

(2) The recipient's name, address, telephone number, and Medicaid identification number.

(3) A preprinted statement that indicates that the recipient would like to appeal the specific adverse determination of which the recipient was notified in the notice.

(3a) The option for the recipient to request an expedited appeal.

(4) A statement informing the recipient that he or she may choose to be represented by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the recipient's signature and date.

(e1) Expedited Appeal Request. – In accordance with 42 C.F.R. § 431.224, a recipient may request that an appeal under subsection (d) of this section be expedited if the time otherwise permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain, or regain maximum function. With regard to a request for an expedited appeal, all of the following apply:

(1) The recipient shall submit any additional documentation from a licensed health care professional with relevant excerpts from the recipient's medical record that was not already provided with regard to the adverse determination to demonstrate the need for an expedited appeal.

(2) The Department shall determine if the recipient's request meets the criteria for an expedited appeal.

(3) If the Department determines that the recipient's request does not meet the criteria for an expedited appeal, then (i) the Department shall make reasonable efforts to give the recipient, or the recipient's parent, guardian, or legal representative, oral notice of the denial as expeditiously as possible and shall follow up with a written notice of denial and (ii) the recipient's appeal shall not

be subject to the expedited time frame in subdivision (4) of this subsection. The denial is not appealable.

(4) If the Department determines that the recipient's request meets the criteria for an expedited appeal, then (i) the mediation procedure under G.S. 108A-70.9B(c) shall not apply to the appeal request and (ii) the decision required under G.S. 108A-70.9B(g) shall be made as expeditiously as possible.

(f) Final Decision. – After a hearing before an administrative law judge, the judge shall return the decision to the Department in accordance with G.S. 150B-37. The Department shall notify the recipient of the final decision and of the right to judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes. (2010-31, s. 10.30(a); 2011-398, s. 32; 2019-81, s. 6; 2021-62, ss. 2.1(a)-(c), 2.2(a), (b); 2022-74, s. 9D.15(z).)

**§ 108A-70.9B. (Effective until contingency met – see note) Contested Medicaid cases.**

(a) Application. – This section applies only to contested Medicaid cases as defined in this Part. Except as otherwise provided by Article 1A of Chapter 108D of the General Statutes, G.S. 108A-70.9A, and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid or NC Health Choice recipient is subject to the provisions of Article 3 of Chapter 150B of the General Statutes. To the extent any provision in this section, Article 1A of Chapter 108D of the General Statutes, or G.S. 108A-70.9A conflicts with another provision in Article 3 of Chapter 150B of the General Statutes, this section, Article 1A of Chapter 108D of the General Statutes, and G.S. 108A-70.9A control.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid or NC Health Choice recipient in order to complete the case as quickly as possible.

(1) To the extent possible, OAH shall schedule and hear contested Medicaid cases within 55 days of submission of a request for appeal.

(2) Hearings shall be conducted telephonically or by video technology with all parties, however the recipient may request that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in Wake County, however, for good cause shown, the in-person hearing may be conducted in the county of residence of the recipient or a nearby county. Good cause shall include, but is not limited to, the recipient's impairments limiting travel or the unavailability of the recipient's treating professional witnesses. The Department shall provide written notice to the recipient of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, and how to request a hearing in the recipient's county of residence.

(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid or NC Health Choice recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.

(4) The administrative law judge may allow brief extensions of the time limits contained in this section for good cause and to ensure that the record is

complete. Good cause includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances. Continuances shall only be granted in accordance with rules adopted by OAH and shall not be granted on the day of the hearing, except for good cause shown. If a petitioner fails to make an appearance at a hearing that has been properly noticed via certified mail by OAH, OAH shall immediately dismiss the contested case, unless the recipient moves to show good cause within three business days of the date of dismissal.

(5) The notice of hearing provided by OAH to the recipient shall include the following information:

a. The recipient's right to examine at a reasonable time before the hearing and during the hearing the contents of the recipient's case file and documents to be used by the Department in the hearing before the administrative law judge.

b. The recipient's right to an interpreter during the appeals process.

c. Circumstances in which a medical assessment may be obtained at agency expense and be made part of the record. Qualifying circumstances include those in which (i) a hearing involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team's decision; and (ii) the administrative law judge considers it necessary to have a medical assessment other than that performed by the individual involved in making the original decision.

(c) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid or NC Health Choice recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the Department within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested Medicaid case until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation.

(d) Burden of Proof. – The recipient has the burden of proof on all issues submitted in a contested Medicaid case to OAH and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

(e) New Evidence. – The recipient shall be permitted to submit evidence regardless of whether obtained prior to or subsequent to the Department's actions and regardless of whether the Department had an opportunity to consider the evidence in making its adverse determination. When the evidence is received, at the request of the Department, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days to allow for the Department's review of the evidence. Subsequent to review of the evidence, if the Department reverses its original decision, it shall immediately inform the administrative law judge.

(f) Issue for Hearing. – For each adverse determination and each adverse disenrollment determination, the hearing shall determine whether the Department substantially prejudiced the

rights of the recipient and if the Department, based upon evidence at the hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(g) Decision. – The administrative law judge assigned to a contested Medicaid case shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision and send it to the parties in accordance with G.S. 150B-37. (2010-31, s. 10.30(a); 2011-398, s. 33; 2014-100, s. 12H.27(b); 2019-81, s. 6.)

**§ 108A-70.9B. (Effective once contingency met – see note) Contested Medicaid cases.**

(a) Application. – This section applies only to contested Medicaid cases as defined in this Part. Except as otherwise provided by Article 1A of Chapter 108D of the General Statutes, G.S. 108A-70.9A, and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid recipient is subject to the provisions of Article 3 of Chapter 150B of the General Statutes. To the extent any provision in this section, Article 1A of Chapter 108D of the General Statutes, or G.S. 108A-70.9A conflicts with another provision in Article 3 of Chapter 150B of the General Statutes, this section, Article 1A of Chapter 108D of the General Statutes, and G.S. 108A-70.9A control.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid recipient in order to complete the case as quickly as possible.

(1) To the extent possible, OAH shall schedule and hear contested Medicaid cases within 55 days of submission of a request for appeal.
(2) Hearings shall be conducted telephonically or by video technology with all parties, however the recipient may request that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in Wake County, however, for good cause shown, the in-person hearing may be conducted in the county of residence of the recipient or a nearby county. Good cause shall include, but is not limited to, the recipient's impairments limiting travel or the unavailability of the recipient's treating professional witnesses. The Department shall provide written notice to the recipient of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, and how to request a hearing in the recipient's county of residence.
(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.
(4) The administrative law judge may allow brief extensions of the time limits contained in this section for good cause and to ensure that the record is

complete. Good cause includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances. Continuances shall only be granted in accordance with rules adopted by OAH and shall not be granted on the day of the hearing, except for good cause shown. If a petitioner fails to make an appearance at a hearing that has been properly noticed via certified mail by OAH, OAH shall immediately dismiss the contested case, unless the recipient moves to show good cause within three business days of the date of dismissal.

(5) The notice of hearing provided by OAH to the recipient shall include the following information:

a. The recipient's right to examine at a reasonable time before the hearing and during the hearing the contents of the recipient's case file and documents to be used by the Department in the hearing before the administrative law judge.

b. The recipient's right to an interpreter during the appeals process.

c. Circumstances in which a medical assessment may be obtained at agency expense and be made part of the record. Qualifying circumstances include those in which (i) a hearing involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team's decision; and (ii) the administrative law judge considers it necessary to have a medical assessment other than that performed by the individual involved in making the original decision.

(c) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the Department within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested Medicaid case until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation.

(d) Burden of Proof. – The recipient has the burden of proof on all issues submitted in a contested Medicaid case to OAH and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

(e) New Evidence. – The recipient shall be permitted to submit evidence regardless of whether obtained prior to or subsequent to the Department's actions and regardless of whether the Department had an opportunity to consider the evidence in making its adverse determination. When the evidence is received, at the request of the Department, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days to allow for the Department's review of the evidence. Subsequent to review of the evidence, if the Department reverses its original decision, it shall immediately inform the administrative law judge.

(f) Issue for Hearing. – For each adverse determination and each adverse disenrollment determination, the hearing shall determine whether the Department substantially prejudiced the

rights of the recipient and if the Department, based upon evidence at the hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(g) Decision. – The administrative law judge assigned to a contested Medicaid case shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision and send it to the parties in accordance with G.S. 150B-37. (2010-31, s. 10.30(a); 2011-398, s. 33; 2014-100, s. 12H.27(b); 2019-81, s. 6; 2022-74, s. 9D.15(z).)

**§ 108A-70.9C. Informal review permitted.**

Nothing in this Part shall prevent the Department from engaging in an informal review of a contested Medicaid case with a recipient prior to issuing a notice of adverse determination under G.S. 108A-70.9A(c) or a notice of resolution under G.S. 108D-5.7. (2010-31, s. 10.30(a); 2019-81, s. 6.)

## Part 7. Medical Assistance Provider False Claims Act.

**§ 108A-70.10. Short title.**

This Part may be cited as the Medical Assistance Provider False Claims Act. (1997-338, s. 1.)

**§ 108A-70.11. Definitions.**

Definitions. – As used in this Part:

(1) "Attorney General" means the Attorney General or any Deputy, Assistant, or Associate Attorney General.
(2) "Claim" means an application for payment or approval or for use in determining entitlement to payment presented to the Medical Assistance Program in any form, including written, electronic, or magnetic, which identifies a service, good, or accommodation as reimbursable under the Medical Assistance Program.
(3) "Damages" means the difference between what the Medical Assistance Program paid a provider and the amount it would have paid the provider in the absence of a violation of this section and may be established by statistical sampling methods.
(4) "Knowingly" means that a provider, with respect to the information:
    a. Has actual knowledge of the information;
    b. Acts in deliberate ignorance of the truth or falsity of the information; or
    c. Acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
(5) "Medical Assistance Program" means the Division of Health Benefits and its fiscal agent. (1997-338, s. 1; 2019-81, s. 15(a).)

**§ 108A-70.12. Liability for certain acts; damages; effect of repayment.**

(a) Liability for Certain Acts. – It shall be unlawful for any provider of medical assistance under the Medical Assistance Program to:

(1) Knowingly present, or cause to be presented to the Medical Assistance Program a false or fraudulent claim for payment or approval; or

(2) Knowingly make, use, or cause to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the Medical Assistance Program.

Each claim presented or caused to be presented in violation of this section is a separate violation.

(b) Damages. –

(1) Except as provided in subdivision (2) of this subsection, a court shall assess against any provider of medical assistance under the Medical Assistance Program who violates this section a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000) plus three times the amount of damages which the Medicaid Assistance Program sustained because of the act of the provider.

(2) A court may assess a penalty of not less than two times the amount of damages which the Medical Assistance Program sustains because of the act of the provider if a court finds that:

a. The provider committing a violation of this section furnished officials of the State responsible for investigating false claims violations with all information known to the provider about the violation within 30 days after the date the provider first obtained the information;

b. The provider fully cooperated with any State investigation of the violation; and

c. At the time the provider furnished the State with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced with respect to the violation, and the provider did not have actual knowledge of the existence of an investigation into the violation.

(3) In addition to the damages and penalty assessed by the court pursuant to subdivision (1) or (2) of this subsection, a provider violating this section shall also be liable for the costs of a civil action brought to recover any penalty or damages, interest on the damages at the maximum legal rate in effect on the date the payment was made to the provider for the period from the date upon which payment was made to the provider to the date upon which repayment is made by the provider to the Medical Assistance Program, and the costs of the investigation.

(4) As applied to providers that are subject to certification review by the Division of Health Service Regulation, a violation of Medicaid provider certification standards in providing a service, good, or accommodation shall not be considered an independent basis for liability under this Act. However, liability may be imposed if a false or fraudulent claim is presented as set forth in subsection (a) of this section in connection with that service, good, or accommodation.

(c) Effect of Repayment. – Intent to repay or repayment of any amounts obtained by a provider as a result of any acts described in subsection (a) of this section shall not be a defense to or grounds for dismissal of an action brought pursuant to this section. However, a court may

consider any repayment in mitigation of the amount of any penalties assessed. (1997-338, s. 1; 2007-182, s. 1.)

**§ 108A-70.13. False claims procedure.**

(a) The Attorney General shall have the authority to investigate, institute proceedings, compromise and settle any investigation or action, and perform all duties in connection with any civil action to enforce G.S. 108A-70.12.

(b) A civil action under G.S. 108A-70.12 may not be brought more than six years after the date the violation of G.S. 108A-70.12 is committed, or more than three years after the date when facts material to the right of action are known or reasonably should have been known by the official of the State of North Carolina charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

(c) In any action brought under G.S. 108A-70.12, the State shall be required to prove all essential elements of the cause of action, including damages, by the greater weight of the evidence.

(d) Notwithstanding any other provision of law or rule, a final judgment rendered in favor of the State in any criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action which involves the same transaction as in the criminal proceeding and which is brought under G.S. 108A-70.12.

(e) No criminal or administrative action need be brought against any provider as a condition for establishing civil liability under G.S. 108A-70.12. The civil liability under G.S. 108A-70.12 is in addition to any other criminal, civil, and administrative liabilities or penalties that may be prescribed by law. However, treble and double damages and civil penalties provided by G.S. 108A-70.12 shall not be assessed against a provider if treble or double damages or civil penalties have been previously assessed against the provider for the same claims under the federal False Claims Act, 31 U.S.C. § 3729, et seq., or the federal Civil Monetary Penalty Law, 42 U.S.C. § 1320a-7a. In the event that any provider is found liable under the provisions of this Act and is subsequently found liable for the same claim under the federal False Claims Act, or the appropriate sections of the federal Civil Monetary Penalty Law, the State and the Medical Assistance Program shall pay to the federal government on behalf of the provider any amounts, other than restitution, recovered or otherwise obtained by the State under this Act, not to exceed the amount of the federal damages and penalties.

(f) The amount of damages and number of violations of G.S. 108A-70.12 shall be established by the trial judge or, in the event of a jury trial, by jury verdict. The amount of penalties, treble or double damages, interest, cost of the investigation, and cost of the civil action shall be determined by the trial judge as prescribed in G.S. 108A-70.12(b).

(g) Venue for any action brought pursuant to G.S. 108A-70.12 shall be in either Wake County or in any county in which claim originated, or in which any statement or record was made, or acts done, or services, goods, or accommodations rendered in connection with any act constituting part of the violation of G.S. 108A-70.12. (1997-338, s. 1.)

**§ 108A-70.14. Civil investigative demand.**

(a) If the Attorney General has reasonable cause to believe that a person has information or is in possession, custody, or control of any document or other tangible object relevant to an investigation or that would lead to the discovery of relevant information in an investigation of a violation of G.S. 108A-70.12, the Attorney General may serve upon the person, before bringing

an action under G.S. 108A-70.12 or other false claims law, a civil investigative demand to appear and be examined under oath, to answer written interrogatories under oath, and to produce any documents or objects for their inspection and copying.

(b) The civil investigative demand shall:

(1) Be served upon the person in the manner required for service of process in civil actions and may be served by the Attorney General or investigator assigned to the North Carolina Department of Justice;

(2) Describe the nature of the conduct constituting the violation under investigation;

(3) Describe the class or classes of any documents or objects to be produced with sufficient definiteness to permit them to be fairly identified;

(4) Contain a copy of any written interrogatories to be answered;

(5) Prescribe a reasonable date and time at which the person shall appear to testify, answer any written interrogatories, or produce any document or object;

(6) Advise the person that objections to or reasons for not complying with the demand may be filed with the Attorney General on or before that date and time;

(7) Specify a place for the taking of testimony;

(8) Designate a person to whom answers to written interrogatories shall be submitted and to whom any document or object shall be produced; and

(9) Contain a copy of subsections (b) and (c) of this section.

(c) The date within which to answer any written interrogatories and within which any document or object must be produced shall be more than 30 days after the civil investigative demand has been served upon the person. The date within which a person must appear to testify shall be more than 15 days after the demand has been served upon a person who resides out-of-state or more than 10 days after the demand has been served upon a person who resides in-state.

(d) The person before whom the oral examination is to be taken shall put the person to be examined on oath and shall personally, or by someone acting under the person's direction and in the person's presence, record the testimony of the person to be examined. The Attorney General may exclude from the place where the examination is held all persons except the person giving the testimony, the attorney or other representative of the person giving the testimony, the Attorney General conducting the examination, the investigator assisting the Attorney General, the stenographer, and any other person agreed upon by the Attorney General and the person giving the testimony. When the testimony is transcribed, the person shall have a reasonable opportunity to examine and read the transcript, unless an examination and reading are waived by the person. Any changes in form or substance which the person desires to make shall be entered and identified upon the transcript by the person. The transcript shall then be signed by the person, unless the person in writing waives the signing, is ill, cannot be found, or refuses to sign.

(e) Each interrogatory in a civil investigative demand served under this section shall be answered separately and fully in writing under oath and shall be submitted under sworn certificate by the person to whom the demand is directed, or in the case of a person other than a natural person, a person having knowledge of the facts and circumstances relating to the production and authorized to act on behalf of the person. If a person objects to any interrogatory, the reasons for the objection shall be stated in the certificate instead of an answer. The certificate shall state that all information required by the demand and in the possession, custody, control, or knowledge of the person to whom the demand is directed has been submitted. To the extent that any information

is not furnished, the information shall be identified and reasons set forth with particularity regarding the reasons why the information was not furnished.

(f) The production of documents and objects in response to a civil investigative demand served under this section shall be made under a sworn certificate by the person to whom the demand is directed, or in the case of a person other than a natural person, a person having knowledge of the facts and circumstances relating to the production and authorized to act on behalf of the person. The certificate shall state that all of the documentary material required by the demand and in the possession, custody, or control of the person to whom the demand is directed has been produced and made available. Upon written agreement between the person served with the civil investigative demand and the Attorney General, the person may substitute copies for originals of all or any part of the documents requested.

(g) No person shall be excused from testifying, answering interrogatories, or producing documents or objects in response to a civil investigative demand on the ground that the testimony, answers, documents, or objects required of the person may tend to incriminate the person. However, no testimony, answers, documents, or objects compelled pursuant to G.S. 108A-70.14 may be used against the person in a criminal action, except a prosecution for perjury or for contempt arising from a failure to comply with an order of the court.

(h) Any person appearing for oral testimony under a civil investigative demand issued pursuant to this section shall be entitled to the same fees and allowances paid to witnesses in the General Court of Justice of the State of North Carolina.

(i) If a person objects to or otherwise fails to comply with a civil investigative demand served upon the person under subsection (a) of this section, the Attorney General may file an action in superior court for an order to enforce the demand. Venue for the action to enforce the demand shall be in either Wake County or the county in which the person resides. Notice of a hearing on the action to enforce the demand and a copy of the action shall be served upon the person in the same manner as prescribed in the Rules for Civil Procedure. If the court finds that the demand is proper, that there is reasonable cause to believe that there may have been a violation of G.S. 108A-70.12, and that the information sought or document or object demanded is relevant to the violation, the court shall order the person to comply with the demand, subject to modifications the court may prescribe.

(j) If the person fails to comply with an order entered pursuant to subsection (i) of this section, the court may:

(1) Adjudge the person to be in contempt of court;

(2) Grant injunctive relief against the person to whom the demand is issued to restrain the conduct which is the subject of the investigation; or

(3) Grant any other relief as the court may deem proper.

(k) Any transcript of oral testimony, answers to written interrogatories, and documents and objects produced pursuant to this section may be used in connection with any civil action brought under G.S. 108A-70.12.

(l) The North Carolina Rules of Civil Procedure shall apply to this section to the extent that the rules are not inconsistent with the provisions of this section. (1997-338, s. 1.)

**§ 108A-70.15. Employee remedies.**

(a) In the absence of fraud or malice, no person who furnishes information to officials of the State responsible for investigating false claims violations shall be liable for damages in a civil

action for any oral or written statement made or any other action that is necessary to supply information required pursuant to this Part.

(b) Any employee of a provider who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the employee's employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under G.S. 108A-70.12, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under G.S. 108A-70.12, shall be entitled to all relief necessary to make the employee whole. Relief shall include reinstatement with the same seniority status as the employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate court for the relief provided in this section. (1997-338, s. 1.)

**§ 108A-70.16. Uniformity of interpretation.**

This Part shall be so interpreted and construed as to be consistent with the federal False Claims Act, 31 U.S.C. § 3729, et seq., and any subsequent amendments to that act. (1997-338, s. 1.)

**§ 108A-70.17. Reserved for future codification purposes.**

Part 8. (Contingently repealed – see note) Health Insurance Program for Children.

**§ 108A-70.18. (Contingently repealed – see note) Definitions.**

As used in this Part, unless the context clearly requires otherwise, the term:

(1) "Comprehensive health coverage" means creditable health coverage as defined under Title XXI.

(2) "Family income" has the same meaning as used in determining eligibility for the Medical Assistance Program.

(3) "FPL" or "federal poverty level" means the federal poverty guidelines established by the United States Department of Health and Human Services, as revised each April 1.

(4) "Medical Assistance Program" means the State Medical Assistance Program established under Part 6 of Article 2 of Chapter 108A of the General Statutes.

(4a) Repealed by Session Laws 2015-96, s. 1, effective June 19, 2015.

(5) "Program" means The Health Insurance Program for Children established in this Part.

(6) "State Plan" means the State Child Health Plan for the State Children's Health Insurance Program established under Title XXI.

(7) "Title XXI" means Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552, codified in scattered sections of 42 U.S.C.

(8) "Uninsured" means the applicant for Program benefits is not covered under any private or employer-sponsored comprehensive health insurance plan on the date of enrollment. (1998-1, s. 1; 1998-166, s. 6; 2000-67, s. 11.8(a); 2000-140, s. 90(d); 2001-424, s. 21.22(b); 2008-107, s. 10.13(d); 2015-96, s. 1; repealed by 2022-74, s. 9D.15(b).)

**§ 108A-70.19. (Contingently repealed – see note) Short title; purpose; no entitlement.**

This Part may be cited as "The Health Insurance Program for Children Act of 1998." The purpose of this Part is to provide comprehensive health insurance coverage to uninsured low-income children who are residents of this State. Coverage shall be provided from federal funds received, State funds appropriated, and other nonappropriated funds made available for this purpose. Nothing in this Part shall be construed as obligating the General Assembly to appropriate funds for the Program or as entitling any person to coverage under the Program. (1998-1, s. 1; repealed by 2022-74, s. 9D.15(b).)

**§ 108A-70.20. (Contingently repealed – see note) Program established.**

The Health Insurance Program for Children is established. The Program shall be known as North Carolina Health Choice for Children, and it shall be administered by the Department of Health and Human Services in accordance with this Part and as required under Title XXI and related federal rules and regulations. Administration of claims processing shall be as described in 42 C.F.R. 447.45(d)(1). (1998-1, s. 1; 2008-107, s. 10.13(e); 2015-96, s. 2; repealed by 2022-74, s. 9D.15(b).)

**§ 108A-70.20A:** Repealed by Session Laws 2015-96, s. 3, effective June 19, 2015.

**§ 108A-70.21. (Contingently repealed – see note) Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans.**

(a) Eligibility. – The Department may enroll eligible children based on availability of funds. Following are eligibility and other requirements for participation in the Program:

(1) Children must:
   a. Be between the ages of 6 through 18;
   b. Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;
   c. Be uninsured;
   d. Be in a family whose family income is above one hundred thirty-three percent (133%) and less than or equal to two hundred eleven percent (211%) of the federal poverty level;
   e. Be a resident of this State and eligible under federal law; and
   f. Have paid the Program enrollment fee required under this Part.

(2) Proof of family income and residency and declaration of uninsured status shall be provided by the applicant at the time of application for Program coverage. The family member who is legally responsible for the children enrolled in the Program has a duty to report any change in the enrollee's status within 60 days of the change of status.

(3) If a responsible parent is under a court order to provide or maintain health insurance for a child and has failed to comply with the court order, then the child is deemed uninsured for purposes of determining eligibility for Program benefits if at the time of application the custodial parent shows proof of agreement to notify and cooperate with the child support enforcement agency in enforcing the order.

If health insurance other than under the Program is provided to the child after enrollment and prior to the expiration of the eligibility period for which the child is enrolled in the Program, then the child is deemed to be insured and

ineligible for continued coverage under the Program. The custodial parent has a duty to notify the Department within 10 days of receipt of the other health insurance, and the Department, upon receipt of notice, shall disenroll the child from the Program. As used in this paragraph, the term "responsible parent" means a person who is under a court order to pay child support.

(4) Except as otherwise provided in this section, enrollment shall be continuous for one year. At the end of each year, applicants may reapply for Program benefits.

(b) Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under [the] North Carolina Medicaid Program except for the following:

(1) No services for long-term care.

(2) No nonemergency medical transportation.

(3) No EPSDT.

(4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.

In addition to the benefits provided under the North Carolina Medicaid Program, the following services and supplies are covered under the Health Insurance Program for Children established under this Part:

(1), (1a) Repealed by Session Laws 2011-145, s. 10.41(b), effective July 1, 2011.

(2) Vision: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every 24 months, and optical supplies and solutions when needed. NCHC recipients must obtain optical services, supplies, and solutions from NCHC enrolled, licensed or certified ophthalmologists, optometrists, or opticians. In accordance with G.S. 148-134, NCHC providers must order complete eyeglasses, eyeglass lenses, and ophthalmic frames through Nash Optical Plant. Eyeglass lenses are limited to NCHC-approved single vision, bifocal, trifocal, or other complex lenses necessary for a Plan enrollee's visual welfare. Coverage for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses, and laminated lenses is limited to the coverage for single vision, bifocal, trifocal, or other complex lenses provided by this subsection. Eyeglass frames are limited to NCHC-approved frames made of zylonite, metal, or a combination of zylonite and metal. All visual aids covered by this subsection require prior approval. Requests for medically necessary complete eyeglasses, eyeglass lenses, and ophthalmic frames outside of the NCHC-approved selection require prior approval. Requests for medically necessary fabrication of complete eyeglasses or eyeglass lenses outside of Nash Optical Plant require prior approval. Upon prior approval refractions may be covered more often than once every 12 months.

(3) Under the North Carolina Health Choice Program for Children, the co-payment for nonemergency visits to the emergency room for children whose family income is less than or equal to one hundred fifty-nine percent (159%) of the federal poverty level is ten dollars ($10.00). The co-payment for children whose

family income is above one hundred fifty-nine percent (159%) and less than or equal to two hundred eleven percent (211%) of the federal poverty level is twenty-five dollars ($25.00).

(4) Over the counter medications: Selected over the counter medications provided the medication is covered under the State Medical Assistance Plan. Coverage shall be subject to the same policies and approvals as required under the Medicaid program.

(5) Routine diagnostic examinations and tests: annual routine diagnostic examinations and tests, including x-rays, blood and blood pressure checks, urine tests, tuberculosis tests, and general health check-ups that are medically necessary for the maintenance and improvement of individual health are covered.

No benefits are to be provided for services and materials under this subsection that do not meet the standards accepted by the American Dental Association.

The Department shall provide services to children enrolled in the NC Health Choice Program through Community Care of North Carolina (CCNC) and shall pay Community Care of North Carolina providers the per member, per month fees as allowed under Medicaid.

(b1) Payments. – Prescription drug providers shall accept as payment in full, for outpatient prescriptions filled, amounts allowable for prescription drugs under Medicaid. For all other providers, services provided to children enrolled in the Program shall be provided at rates equivalent to one hundred percent (100%) of Medicaid rates, less any co-payments assessed to enrollees under this Part.

(c) Annual Enrollment Fee. – There shall be no enrollment fee for Program coverage for enrollees whose family income is less than or equal to one hundred fifty-nine percent (159%) of the federal poverty level. The enrollment fee for Program coverage for enrollees whose family income is above one hundred fifty-nine percent (159%) and less than or equal to two hundred eleven percent (211%) of the federal poverty level shall be fifty dollars ($50.00) per year per child with a maximum annual enrollment fee of one hundred dollars ($100.00) for two or more children. The enrollment fee shall be collected by the county department of social services and retained to cover the cost of determining eligibility for services under the Program. County departments of social services shall establish procedures for the collection of enrollment fees.

(d) Cost-Sharing. – There shall be no deductibles, copayments, or other cost-sharing charges for families covered under the Program whose family income is less than or equal to one hundred fifty-nine percent (159%) of the federal poverty level, except that fees for outpatient prescription drugs are applicable and shall be one dollar ($1.00) for each outpatient generic prescription drug, for each outpatient brand-name prescription drug for which there is no generic substitution available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is three dollars ($3.00). Families covered under the Program whose family income is above one hundred fifty-nine percent (159%) of the federal poverty level shall be responsible for copayments to providers as follows:

(1) Five dollars ($5.00) per child for each visit to a provider, except that there shall be no copayment required for well-baby, well-child, or age-appropriate immunization services;

(2) Five dollars ($5.00) per child for each outpatient hospital visit;

(3) A one dollar ($1.00) fee for each outpatient generic prescription drug, for each outpatient brand-name prescription drug for which there is no generic substitution available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is ten dollars ($10.00).

(4) Twenty dollars ($20.00) for each emergency room visit unless:

a. The child is admitted to the hospital, or

b. No other reasonable care was available as determined by the Department.

Copayments required under this subsection for prescription drugs apply only to prescription drugs prescribed on an outpatient basis.

(e) Cost-Sharing Limitations. – The Department shall establish maximum annual cost-sharing limits per individual or family, provided that the total annual aggregate cost-sharing, including enrollment fees, with respect to all children in a family receiving benefits under this section shall not exceed five percent (5%) of the family's income for the year involved.

(f) Coverage From Private Plans. – The Department shall, from funds available for the Program, pay the cost for dependent coverage provided under a private insurance plan for persons eligible for coverage under the Program if all of the following conditions are met:

(1) The person eligible for Program coverage requests to obtain dependent coverage from a private insurer in lieu of coverage under the Program and shows proof that coverage under the private plan selected meets the requirements of this subsection;

(2) The dependent coverage under the private plan is actuarially equivalent to the coverage provided under the Program and the private plan does not engage in the exclusive enrollment of children with favorable health care risks;

(3) The cost of dependent coverage under the private plan is the same as or less than the cost of coverage under the Program; and

(4) The total annual aggregate cost-sharing, including fees, paid by the enrollee under the private plan for all dependents covered by the plan, do not exceed five percent (5%) of the enrollee's family income for the year involved.

The Department may reimburse an enrollee for private coverage under this subsection upon a showing of proof that the dependent coverage is in effect for the period for which the enrollee is eligible for the Program.

(g), (h) Repealed by Session Laws 2015-241, s. 12H.14(a), effective September 18, 2015.

(i) Benefits provided to an enrollee in the Program may be subject to lifetime maximum limits set forth in Medicaid and NC Health Choice medical coverage policies adopted pursuant to G.S. 108A-54.2. (1998-1, s. 1; 1999-237, s. 11.9; 2002-126, s. 10.20(a); 2003-284, s. 10.29(a); 2005-276, ss. 10.22(b), 10.22(c), 10.22(d); 2007-323, s. 28.22A(o); 2007-345, s. 12; 2008-107, ss. 10.12(b), (c), 10.13(f), (k); 2008-118, s. 1.6(b), (c); 2009-16, s. 4(d); 2009-451, s. 10.35(a); 2011-145, s. 10.41(b); 2013-360, s. 12H.10(g); 2015-96, s. 4; 2015-241, ss. 12H.2(f), 12H.14(a), (b), 12H.25(b), 12H.26(b); 2015-245, s. 22; 2017-102, s. 16; repealed by 2022-74, s. 9D.15(b).)

**§ 108A-70.22:** Repealed by Session Laws 2008-107, s. 10.13(g), effective July 1, 2008.

**§ 108A-70.23:** Repealed by Session Laws 2011-145, s. 10.41(c), effective July 1, 2011.

**§ 108A-70.24:** Repealed by Session Laws 2008-107, s. 10.13(i), effective July 1, 2008.

**§ 108A-70.25. (Contingently repealed – see note) State Plan for Health Insurance Program for Children.**

(a) The NC Health Choice program shall be administered and operated in accordance with this Part and the NC Health Choice State Plan, as periodically amended by the Department of Health and Human Services and approved by the federal government.

(b) The requirements in G.S. 108A-54.1A shall apply to NC Health Choice State Plan amendments in the same manner in which they apply to Medicaid State Plan amendments. (1998-1, s. 1; 2011-291, s. 2.23; 2013-360, s. 12H.2(b); repealed by 2022-74, s. 9D.15(b).)

**§ 108A-70.26. (Contingently repealed – see note) Application process; outreach efforts; appeals.**

(a) Application. – The Department shall use an application form for the Program that is concise, relatively easy for the applicant to comprehend and complete, and only as lengthy as necessary for identifying applicants, determining eligibility for the Program or Medicaid, and providing information to applicants on requirements for application submission and proof of eligibility. Application forms shall be obtainable from public health departments and county departments of social services. Applications shall be processed by the county department of social services and may be submitted by mail. The Department may adopt rules for the submission and processing of applications and for securing the proof of eligibility for benefits under this Part.

The application form for the Program shall have printed on it or attached to it a notice stating substantially: "The Health Insurance Program for Children is a federally and State funded program that may be discontinued if federal funds are not provided for its continuation."

(b) Outreach Efforts. – The Department shall adopt procedures to ensure that the Program is adequately publicized statewide and to comply with federal outreach requirements. The Department shall make information about the Program available through the Internet and shall explore the feasibility of securing a 24-hour toll-free telephone number to facilitate access to Program information. In order to avoid duplication of efforts, in developing outreach procedures the Department shall establish system linkages to ensure the collaboration and coordination of information between and among the Program and such ongoing programs and efforts as:

WIC Program.

Maternal and Child Health Block Grant.

Children's Special Health Services.

Smart Start.

Head Start.

The Department shall seek private and federal grant funds for outreach activities. The Department shall also seek the participation of the private sector in providing no-cost or low-cost avenues for publicizing the Program in local communities and statewide. The Department may work with the State Health Plan Purchasing Alliance Board to develop programs that utilize the expertise and resources of the Alliances in outreach activities to employees of small businesses.

(c) Appeals. – A person who is dissatisfied with the action of a county department of social services with respect to the determination of eligibility for benefits under the Program may appeal the action in accordance with G.S. 108A-79. (1998-1, s. 1; repealed by 2022-74, s. 9D.15(b).)

**§ 108A-70.27. (Contingently repealed – see note) Data collection; reporting.**

(a) The Department shall ensure that the following data are collected, analyzed, and reported in a manner that will most effectively and expeditiously enable the State to evaluate Program goals, objectives, operations, and health outcomes for children:

(1) Number of applicants for coverage under the Program;
(2) Number of Program applicants deemed eligible for Medicaid;
(3) Number of applicants deemed eligible for the Program, by income level, age, and family size;
(4) Number of applicants deemed ineligible for the Program and the basis for ineligibility;
(5) Number of applications made at county departments of social services, public health departments, and by mail;
(6) Total number of children enrolled in the Program to date and for the immediately preceding fiscal year;
(7) Total number of children enrolled in Medicaid through the Program application process;
(8) Trends showing the Program's impact on hospital utilization, immunization rates, and other indicators of quality of care, and cost-effectiveness and efficiency;
(9) Trends relating to the health status of children;
(10) Other data that would be useful in carrying out the purposes of this Part.

(b) Repealed by Session Laws 2013-360, s. 12A.8(e), effective July 1, 2013.

(c) The Division of Health Benefits shall provide to the Department data required under this section that are collected by this Division. Data shall be reported by the Division of Health Benefits in sufficient detail to meet federal reporting requirements under Title XXI. (1998-1, s. 1; 2011-145, s. 10.41(d); 2011-291, ss. 2.24, 2.25; 2013-360, s. 12A.8(e); 2015-96, s. 5; 2019-81, s. 15(a); repealed by 2022-74, s. 9D.15(b).)

**§ 108A-70.28. (Contingently repealed – see note) Fraudulent misrepresentation.**

(a) It shall be unlawful for any person to knowingly and willfully, and with intent to defraud, make or cause to be made a false statement or representation of a material fact in an application for coverage under this Part or intended for use in determining eligibility for coverage.

(b) It shall be unlawful for any applicant, recipient, or person acting on behalf of the applicant or recipient to knowingly and willfully, and with intent to defraud, conceal, or fail to disclose any condition, fact, or event affecting the applicant's or recipient's initial or continued eligibility to receive coverage or benefits under this Part.

(c) It is unlawful for any person knowingly, willingly, and with intent to defraud, to obtain or attempt to obtain, or to assist, aid, or abet another person, either directly or indirectly, to obtain money, services, or any other thing of value to which the person is not entitled as a recipient under this Part, or otherwise to deliberately misuse a Program identification card. This misuse includes the sale, alteration, or lending of the Program identification card to others for services and the use of the card by someone other than the recipient to receive or attempt to receive Program coverage for services rendered to that individual.

Proof of intent to defraud does not require proof of intent to defraud any particular person.

(d) A person who violates a provision of this section shall be guilty of a Class I felony.

(e) For purposes of this section the word "person" includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity, or organization. (1998-1, s. 1; repealed by 2022-74, s. 9D.15(b).)

**§ 108A-70.29. (Contingently repealed – see note) Program review process.**

(a) Review of Eligibility and Program Enrollment Decisions. – Eligibility and Program enrollment decisions for Program applicants or recipients shall be reviewable pursuant to G.S. 108A-79. Program recipients shall remain enrolled in the NC Health Choice Program during the review of a decision to terminate or suspend enrollment. This subsection does not apply to requests for disenrollment from a PHP under Article 1A of Chapter 108D of the General Statutes.

(b) Review of Fee-for-Service Program Health Services Decisions. – This subsection applies only to health services decisions for services being provided to NC Health Choice recipients through the fee-for-service program as defined in G.S. 108A-24. This subsection does not apply to adverse benefit determinations as defined in G.S. 108D-1. In accordance with 42 C.F.R. § 457.1130 and 42 C.F.R. § 457.1150, a Program recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

(1) Internal review. – Within 30 days from the date of the decision subject to review under this subsection, a recipient may request a first-level internal review, which shall be conducted by the Clinical Medical Director of the Division of Health Benefits or the Director's clinical designee.

(2) External review. – If the recipient is dissatisfied with the first-level review decision, then within 15 days after the internal review decision is rendered the recipient may request a second-level independent external review by the Department of Health and Human Services Hearing Office. The external review process shall comply with the provisions of 42 C.F.R. § 457.1140. The Department's Hearing Office shall assign the matter to a hearing officer who will preside over the review. The hearing may be in person at the Hearing Office in Raleigh or by telephone. Recipients may:
   a. Represent themselves or have representatives of their choosing in the review process.
   b. Review, in a timely manner, their files and other applicable information relevant to the review of the decision.
   c. Fully participate in the review process, including the opportunity to present supplemental information during the review process.

(3) Time frames. – The hearing officer shall render a written decision within 90 calendar days of the date the recipient requested first-level review, as specified at 42 C.F.R. § 457.1160. If the recipient's physician or health plan determines that operating under the standard 90-day time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, then each level of review must be completed within 72 hours, except that this expedited time frame may be extended by up to 14 calendar days if the recipient requests an extension.

(4) Coverage of services during review. – When the decision is a reduction, suspension, termination, or denied request for increase of existing services, notwithstanding the request for review, the services shall be covered in

accordance with the decision under review, and services which are terminated or suspended services shall not be covered, unless and until the decision is overturned on review.

(c) Review of decisions pursuant to Programmatic changes. – The Program review process set forth in this section shall not apply to instances in which the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

(d) Notice. – A recipient shall receive timely written notice of any decision subject to review under this section in accordance with the requirements of 42 C.F.R. § 457.1180. The notice shall include the reasons for the decision, an explanation of applicable rights to review of that decision, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

(e) Rule-Making authority. – The Department shall have the authority to adopt rules for the implementation and operation of the Program review process.

(f) Additional Rule-Making Authority. – The Department of Health and Human Services shall have the authority to adopt rules for the transition and operation of the North Carolina Health Choice Program. Notwithstanding G.S. 150B-21.1(a), the Department of Health and Human Services may adopt temporary rules in accordance with Chapter 150B of the General Statutes for enrolling providers to participate in the NC Health Choice Program, for regulating provider participation in the NC Health Choice Program, and for other operational issues regarding the NC Health Choice Program. (2010-70, s. 1; 2010-96, s. 39(a); 2011-145, s. 10.41(e); 2019-81, ss. 7, 15(a); repealed by 2022-74, s. 9D.15(b).)

Part 9. Weatherization Assistance Program and Heating/Air Repair and Replacement Program.

**§ 108A-70.30:** Recodified as Part 33 of Article 7 of Chapter 143B, G.S. 143B-344.46, by Session Laws 2013-360, s. 15.22(h), effective July 1, 2013.

**§ 108A-70.31:** Reserved for future codification purposes.

**§ 108A-70.32:** Reserved for future codification purposes.

**§ 108A-70.33:** Reserved for future codification purposes.

**§ 108A-70.34:** Reserved for future codification purposes.

**§ 108A-70.35:** Reserved for future codification purposes.

Part 10. Medicaid Eligibility Decision Processing Timeliness.

**§ 108A-70.36. Applicability.**

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. (2016-94, s. 12H.17(b).)

**§ 108A-70.37. Timely decision standards.**

The county department of social services shall render a decision on an individual's application for Medicaid within 45 calendar days from the date of application, except for applications in which a disability determination has already been made or is needed. For those applications, the county department of social services shall render a decision on an individual's eligibility within 90 calendar days from the date of application. (2016-94, s. 12H.17(b).)

**§ 108A-70.38. Timely processing standards.**

(a) The Department shall require counties to comply with timely processing standards. The timely processing standards are the average processing time standards and the percentage processed timely standards set forth in G.S. 108A-70.39 and G.S. 108A-70.40. The Department shall monitor county department of social services' compliance with these standards in accordance with this Part.

(b) For purposes of this Part, processing time is the number of days between the date of application and the date of disposition of the application, except in cases where an eligibility determination is dependent upon receipt of information related to one or more of the following:

(1) Medical expenses sufficient to meet a deductible.
(2) The applicant's need for institutionalization.
(3) The applicant's plan of care for the home- and community-based waivers.
(4) The disability decision made by the Disability Determination Services Section of the Division of Vocational Rehabilitation of the Department.
(5) Medical records needed to determine emergency dates for nonqualified aliens.
(6) The applicant's application or other information from the federally facilitated marketplace.
(7) The applicant's application or other information in connection with an application for a Low Income Subsidy for Medicare prescription drug coverage.

In these cases, processing time shall exclude the number of days between the date when the county determines all eligibility criteria other than the criteria in subdivisions (1) through (7) of this subsection and the date when the county receives the information related to the criteria in subdivisions (1) through (7) of this subsection.

(c) Processing times for the following types of cases shall be excluded from the calculation of the average processing time and percent processed timely:

(1) Newborns who are automatically enrolled based on their mother's eligibility.
(2) Applications for individuals who are presumptively eligible for Medicaid.
(3) Active cases in which an individual who is eligible for one program is transferred to another program, regardless of whether the transfer occurs between allowable or nonallowable program categories.
(4) Cases in which an individual transfers from an open case to another case, including establishing a new administrative case for the individual.
(5) Actions to post eligibility to a terminated or denied case within one year of the termination or denial.
(6) Cases that are reopened because they were terminated in error or because reopening of the terminated case is allowed by policy.
(7) Cases in which the eligibility decision was appealed and the decision was reversed or remanded.

(d) The Department may, in its discretion, exclude days, other than those required by subsection (b) of this section, from the calculation of processing time under this section if the

Department determines that the delay was caused by circumstances outside the control of county departments of social services. The Department also may, in its discretion, exclude types of cases, other than those described in subsection (c) of this section, from the calculation of processing time. When the Department exercises its discretion pursuant to this subsection, the Department's determination regarding circumstances outside the control of county departments of social services and the Department's decision to exclude types of cases shall be applied uniformly to all county departments of social services. (2016-94, s. 12H.17(b).)

**§ 108A-70.39. Average processing time standards.**

(a) Average processing time is calculated by finding the processing time for each case that received a disposition during a given month and finding the average of those processing times.

(b) The standard for average processing time is 90 days for cases in which the individual has applied for the Medicaid Aid to the Disabled category (M-AD) and 45 days for all other cases. (2016-94, s. 12H.17(b).)

**§ 108A-70.40. Percentage processed timely standards.**

(a) Percentage processed timely is the percentage of cases that received a timely disposition in a given month. The percentage processed timely is calculated by expressing the number of cases during a given month with a processing time equal to or less than the standard set in G.S. 108A-70.37 as a percentage of the total cases receiving a disposition during that month. When the deadline for meeting the timely decision standard in G.S. 108A-70.37 falls on a weekend or holiday, an application that receives a disposition on the first workday following the deadline shall be considered timely for purposes of calculating the percentage processed timely.

(b) The Department is authorized to adopt rules to establish a percentage standard for each county department of social services that will be the percentage processed timely standard for that county department of social services. Until the Department adopts rules establishing percentage standards for each county, the percentage processed timely standards are those established in 10A NCAC 23C .0203 as of April 2016. (2016-94, s. 12H.17(b).)

**§ 108A-70.41. Corrective action.**

(a) If for any three consecutive months or for any five months out of a period of 12 consecutive months a county department of social services fails to meet either the average processing time standard or the percentage processed timely standard or both standards, the Department and the county department of social services shall enter into a joint corrective action plan to improve the timely processing of applications.

(b) A joint corrective action plan entered into pursuant to this section shall specifically identify the following components:

(1) The duration of the joint corrective action plan, not to exceed 12 months. If a county department of social services shows measurable progress in meeting the performance requirements in the joint corrective action plan, then the duration of the joint corrective action plan may be extended by six months, but in no case shall a joint corrective action plan exceed 18 months.

(2) A plan for improving timely processing of applications that specifically describes the actions to be taken by the county department of social services and the Department.

(3) The performance requirements for the county department of social services that constitute successful completion of the joint corrective action plan.

(4) Acknowledgement that failure to successfully complete the joint corrective action plan will result in temporary assumption of Medicaid eligibility administration by the Department, in accordance with G.S. 108A-70.42. (2016-94, s. 12H.17(b).)

**§ 108A-70.42. Temporary assumption of Medicaid eligibility administration.**

(a) If a county department of social services fails to successfully complete its joint corrective action plan, the Department shall give the county department of social services, the county manager, and the board of social services or the consolidated human services board created pursuant to G.S. 153A-77(b) at least 90 days' notice that the Department intends to temporarily assume Medicaid eligibility administration, in accordance with subsection (b) of this section. The notice shall include the following information:

(1) The date on which the Department intends to temporarily assume administration of Medicaid eligibility decisions.

(2) The performance requirements in the joint corrective action plan that the county department of social services failed to meet.

(3) Notice of the county department of social services' right to appeal the decision to the Office of Administrative Hearings, pursuant to Article 3 of Chapter 150B of the General Statutes.

(b) Notwithstanding any provision of law to the contrary, if a county department of social services fails to successfully complete its joint corrective action plan, the Department shall temporarily assume Medicaid eligibility administration for the county upon giving notice as required by subsection (a) of this section. During a period of temporary assumption of Medicaid eligibility administration, the following shall occur:

(1) The Department shall administer the Medicaid eligibility function in the county. Administration by the Department may include direct operation by the Department, including supervision of county Medicaid eligibility workers, or contracts for operation to the extent permitted by federal law and regulations.

(2) The county department of social services is divested of Medicaid administration authority.

(3) The Department shall direct and oversee the expenditure of all funding for the administration of Medicaid eligibility in the county.

(4) The county shall continue to pay the nonfederal share of the cost of Medicaid eligibility administration and shall not withdraw funds previously obligated or appropriated for Medicaid eligibility administration.

(5) The county shall pay the nonfederal share of additional costs incurred to ensure compliance with the timely processing standards required by this Part.

(6) The Department shall work with the county department of social services to develop a plan for the county department of social services to resume Medicaid eligibility administration and perform Medicaid eligibility determinations in a timely manner.

(7) The Department shall inform the county board of commissioners, the county manager, the county director of social services, and the board of social services or the consolidated human services board created pursuant to G.S. 153A-77(b)

of key activities and any ongoing concerns during the temporary assumption of Medicaid eligibility administration.

(c) Upon the Department's determination that Medicaid eligibility determinations can be performed in a timely manner based on the standards set forth in G.S. 108A-70.39 and G.S. 108A-70.40 by the county department of social services, the Department shall notify the county department of social services, the county manager, and the board of social services or the consolidated human services board created pursuant to G.S. 153A-77(b) that temporary assumption of Medicaid eligibility administration will be terminated and the effective date of termination. Upon termination, the county department of social services resumes its full authority to administer Medicaid eligibility determinations. (2016-94, s. 12H.17(b).)

**§ 108A-70.43. (Effective until contingency met – see note) Reporting.**

No later than November 1 of each year, the Department shall submit a report for the prior fiscal year to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division containing the following information:

(1) The annual statewide percentage of Medicaid applications processed in a timely manner for the fiscal year.
(2) The statewide average number of days to process Medicaid applications for each month in the fiscal year.
(3) The annual percentage of Medicaid applications processed in a timely manner by each county department of social services for the fiscal year.
(4) The average number of days to process Medicaid applications for each month for each county department of social services.
(5) The number of months during the fiscal year that each county department of social services met the timely processing standards under G.S. 108A-70.38.
(6) The number of months during the fiscal year that each county department of social services failed to meet the timely processing standards under G.S. 108A-70.38.
(7) A description of all corrective action activities conducted by the Department and county departments of social services in accordance with G.S. 108A-70.36.
(8) A description of how the Department plans to assist county departments of social services in meeting timely processing standards for Medicaid applications, for every county in which the performance metrics for processing Medicaid applications in a timely manner do not show significant improvement compared to the previous fiscal year. (2017-57, s. 11H.21.)

**§ 108A-70.43. (Effective once contingency met – see note) Reporting.**

No later than November 1 of each year, the Department shall submit a report for the prior fiscal year to the Joint Legislative Oversight Committee on Medicaid, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division containing the following information:

(1) The annual statewide percentage of Medicaid applications processed in a timely manner for the fiscal year.
(2) The statewide average number of days to process Medicaid applications for each month in the fiscal year.

(3) The annual percentage of Medicaid applications processed in a timely manner by each county department of social services for the fiscal year.
(4) The average number of days to process Medicaid applications for each month for each county department of social services.
(5) The number of months during the fiscal year that each county department of social services met the timely processing standards under G.S. 108A-70.38.
(6) The number of months during the fiscal year that each county department of social services failed to meet the timely processing standards under G.S. 108A-70.38.
(7) A description of all corrective action activities conducted by the Department and county departments of social services in accordance with G.S. 108A-70.36.
(8) A description of how the Department plans to assist county departments of social services in meeting timely processing standards for Medicaid applications, for every county in which the performance metrics for processing Medicaid applications in a timely manner do not show significant improvement compared to the previous fiscal year. (2017-57, s. 11H.21; 2022-74, s. 9D.15(z), (bb).)

Part 11. Medicaid Eligibility Determinations Accuracy and Quality Assurance.

**§ 108A-70.45. Applicability.**

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. (2017-57, s. 11H.22(c).)

**§ 108A-70.46. Audit of county Medicaid determinations.**

(a) Beginning January 1, 2019, the Department of Health and Human Services, Division of Central Management and Support, shall audit county departments of social services for compliance with the accuracy standards adopted under G.S. 108A-70.47 for Medicaid eligibility determinations made within a 12-month period. This audit shall also include an evaluation of compliance with the quality assurance standards under G.S. 108A-70.48 by the county department of social services. Audits shall be conducted for initial Medicaid eligibility determination applications as well as Medicaid reenrollment determinations. The Department shall ensure that every county is audited no less than once every three years.

(b) Beginning 18 months after the Department has implemented the training and certification program under G.S. 108A-26.5, the Department shall include in its audits required under this section a verification that all county departments of social services are in compliance with the certification program requirements for individuals involved in the Medicaid eligibility determination process. (2017-57, s. 11H.22(c), (h); 2018-5, s. 11H.5(a), (d).)

**§ 108A-70.47. Medicaid eligibility determination processing accuracy standards.**

(a) The Department shall require county departments of social services to comply with accuracy standards set forth in rule for the processing of Medicaid eligibility determinations. The Department shall set the following standards:

(1) Accuracy standards with regards to errors that caused an ineligible Medicaid recipient to be approved for Medicaid benefits.

(2) Accuracy standards with regards to errors that caused the denial of benefits to an applicant that should have been approved for Medicaid benefits.

(3) Accuracy standards with regards to errors made during the eligibility determination process that did not change the outcome of the eligibility determination.

(b) Standards under this section shall be developed by the Department in consultation with the State Auditor. (2017-57, s. 11H.22(c).)

**§ 108A-70.48. Quality assurance.**

The Department shall require county departments of social services to comply with quality assurance minimum standards set forth in rule. The quality assurance standards shall be based upon best practices and shall be developed by the Department in consultation with the State Auditor. (2017-57, s. 11H.22(c).)

**§ 108A-70.49. Corrective action.**

(a) If the Department's audit under G.S. 108A-70.46 results in a determination that a county department of social services fails to meet any of the standards adopted under G.S. 108A-70.47 or G.S. 108A-70.48, the Department and the county department of social services shall enter into a joint corrective action plan to improve the accurate processing of applications.

(b) A joint corrective action plan entered into pursuant to this section shall specifically identify the following components:

(1) The duration of the joint corrective action plan, not to exceed 24 months. If a county department of social services shows measurable progress in meeting the performance requirements in the joint corrective action plan, then the duration of the joint corrective action plan may be extended by six months, but in no case shall a joint corrective action plan exceed 36 months.

(2) A plan for improving the accurate processing of applications that specifically describes the actions to be taken by the county department of social services and the Department.

(3) The performance requirements for the county department of social services that constitute successful completion of the joint corrective action plan.

(4) Acknowledgment that failure to successfully complete the joint corrective action plan will result in temporary assumption of Medicaid eligibility administration by the Department, in accordance with G.S. 108A-70.50.

(c) Any county department of social services under a joint corrective action plan shall be audited under G.S. 108A-70.46 on an annual basis until the joint corrective action plan is successfully completed or until the failure to successfully complete the joint corrective action plan results in the temporary assumption of Medicaid eligibility administration by the Department, in accordance with G.S. 108A-70.50. (2017-57, s. 11H.22(c); 2018-5, s. 11H.5(b).)

**§ 108A-70.50. Temporary assumption of Medicaid eligibility administration.**

(a) If a county department of social services fails to successfully complete its joint corrective action plan, the Department shall give the county department of social services, the county manager, and the board of social services or the consolidated human services board, created pursuant to G.S. 153A-77(b), at least 90 days' notice that the Department intends to temporarily

assume Medicaid eligibility administration, in accordance with subsection (b) of this section. The notice shall include the following information:

(1) The date on which the Department intends to temporarily assume administration of Medicaid eligibility determinations.

(2) The performance requirements in the joint corrective action plan that the county department of social services failed to meet.

(3) Notice of the county department of social services' right to appeal the decision to the Office of Administrative Hearings, pursuant to Article 3 of Chapter 150B of the General Statutes.

(b) Notwithstanding any provision of law to the contrary, if a county department of social services fails to successfully complete its joint corrective action plan, the Department shall temporarily assume Medicaid eligibility administration for the county upon giving notice as required by subsection (a) of this section. During a period of temporary assumption of Medicaid eligibility administration, the following shall occur:

(1) The Department shall administer the Medicaid eligibility function in the county. Administration by the Department may include direct operation by the Department, including supervision of county Medicaid eligibility workers or contracts for operation to the extent permitted by federal law and regulations.

(2) The county department of social services is divested of the authority to administer Medicaid eligibility determinations.

(3) The Department shall direct and oversee the expenditure of all funding for the administration of Medicaid eligibility in the county.

(4) The county shall continue to pay the nonfederal share of the cost of Medicaid eligibility administration and shall not withdraw funds previously obligated or appropriated for Medicaid eligibility administration.

(5) The county shall pay the nonfederal share of additional costs incurred to ensure compliance with the accuracy and quality assurance standards required by this Part.

(6) The Department shall work with the county department of social services to develop a plan for the county department of social services to resume Medicaid eligibility administration and perform Medicaid eligibility determinations more accurately.

(7) The Department shall inform the county board of commissioners, the county manager, the county director of social services, and the board of social services or the consolidated human services board, created pursuant to G.S. 153A-77(b), of key activities and any ongoing concerns during the temporary assumption of Medicaid eligibility administration.

(c) Upon the Department's determination that Medicaid eligibility determinations can be performed accurately and with proper quality assurance by the county department of social services based on the standards adopted under G.S. 108A-70.47 and G.S. 108A-70.48, the Department shall notify the county department of social services, the county manager, and the board of social services or the consolidated human services board, created pursuant to G.S. 153A-77(b), that temporary assumption of Medicaid eligibility administration will be terminated and the effective date of termination. Upon termination, the county department of social services resumes its full authority to administer Medicaid eligibility determinations. (2017-57, s. 11H.22(c).)

**§ 108A-70.51. (Effective until contingency met – see note) Reporting.**

Beginning with the calendar year 2020, no later than March 1 of each year, the Department shall submit a report to the Joint Legislative Committee on Medicaid and NC Health Choice, the Fiscal Research Division, and the State Auditor that contains the following information about the prior calendar year:

(1) The percentage of audited county departments of social services that met the accuracy standards adopted under G.S. 108A-70.47 in the prior fiscal year.

(2) The percentage of audited county departments of social services that met the quality assurance standards adopted under G.S. 108A-70.48 in the prior fiscal year.

(3) The audit result for each standard adopted under G.S. 108A-70.47 for each county of department services in the prior fiscal year.

(4) The number of years in the preceding 10-year period that any county department of social services failed to meet the standards in G.S. 108A-70.47 or G.S. 108A-70.48.

(5) A description of all corrective action activities conducted by the Department and county departments of social services in accordance with G.S. 108A-70.49.

(6) For every county in which the performance metrics for processing Medicaid applications in an accurate manner do not show significant improvement compared to the previous audit of that county, a description of how the Department plans to assist county departments of social services in accuracy and quality assurance standards for Medicaid applications. (2017-57, s. 11H.22(c); 2018-5, s. 11H.5(c).)

**§ 108A-70.51. (Effective once contingency met – see note) Reporting.**

Beginning with the calendar year 2020, no later than March 1 of each year, the Department shall submit a report to the Joint Legislative Oversight Committee on Medicaid, the Fiscal Research Division, and the State Auditor that contains the following information about the prior calendar year:

(1) The percentage of audited county departments of social services that met the accuracy standards adopted under G.S. 108A-70.47 in the prior fiscal year.

(2) The percentage of audited county departments of social services that met the quality assurance standards adopted under G.S. 108A-70.48 in the prior fiscal year.

(3) The audit result for each standard adopted under G.S. 108A-70.47 for each county of department services in the prior fiscal year.

(4) The number of years in the preceding 10-year period that any county department of social services failed to meet the standards in G.S. 108A-70.47 or G.S. 108A-70.48.

(5) A description of all corrective action activities conducted by the Department and county departments of social services in accordance with G.S. 108A-70.49.

(6) For every county in which the performance metrics for processing Medicaid applications in an accurate manner do not show significant improvement compared to the previous audit of that county, a description of how the Department plans to assist county departments of social services in accuracy

and quality assurance standards for Medicaid applications. (2017-57, s. 11H.22(c); 2018-5, s. 11H.5(c); 2022-74, s. 9D.15(i).)