NORTH CAROLINA GENERAL ASSEMBLY

2025 Session

Legislative Fiscal Note

Short Title: Aging With Dignity Act.
Bill Number: House Bill 1138 (First Edition)
Sponsor(s): Rep. Ball, Rep. G. Pierce, Rep. G. Brown, and Rep. Pittman

SUMMARY TABLE

FISCAL IMPACT OF H.B. 1138, V.1 ($ in thousands)

	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31
State Impact					
General Fund Revenue	-	-	-	-	-
Less Expenditures	147,750,000	27,000,000	13,500,000	13,500,000	13,500,000
General Fund Impact	**(147,750,000)**	**(27,000,000)**	**(13,500,000)**	**(13,500,000)**	**(13,500,000)**
NET STATE IMPACT	**(147,750,000)**	**(27,000,000)**	**(13,500,000)**	**(13,500,000)**	**(13,500,000)**

FISCAL IMPACT SUMMARY

Part II of House Bill 1138 requires the Department of Health and Human Services (DHHS) to establish a policy which would default Medicaid beneficiaries to receive home- and community-based services (HCBS) over institutional placement, implement periodic medication reviews, integrate behavioral health services, and screen for social isolation among Medicaid beneficiaries aged 55 and older receiving long-term services and supports (LTSS). This section may have a fiscal impact on State-funded Medicaid expenditures, however, the amount cannot be determined at this time because data on the affected population, DHHS's current practice, and its approach to implementation is not available at the time of publishing this analysis.

Part III of House Bill 1138 establishes various programs within DHHS designed to address the needs of older North Carolinians. Section 3.1 provides DHHS with $120 million in nonrecurring, non-reverting funds to establish and operate a pilot program that would integrate health and support services into a residential facility for older adults who are dually eligible for Medicare and Medicaid. Section 3.2 appropriates $3.5 million in recurring funds to the Division of Aging to improve the efficacy, accessibility, and timeliness of services provided by the Office of the Long-Term Care Ombudsman. Section 3.3 amends Article 3 of Chapter 143B of the General Statutes to establish a program aimed at increasing the supply, geographic distribution, retention, and advancement of workers in professions that provide health and support services to older adults in a variety of settings and appropriates $10 million in recurring funds to DHHS to establish and

administer the program. Lastly, Section 3.4 directs the Division of Health Benefits (DHB) to implement a family caregiver support stipend pilot program for eligible caregivers of Medicaid beneficiaries receiving long-term services and supports and appropriates $13.5 million in recurring funds and $750,000 in nonrecurring funds beginning in FY 2026–27 to do so.

Part IV of House Bill 1138 reestablishes the Aging Study Commission and would not have a State fiscal impact.

FISCAL ANALYSIS

Part II

Section 2.1: Home- and Community-Based Services Presumption

Section 2.1 establishes a policy presumption favoring HCBS over institutional placement for Medicaid beneficiaries aged 55 and older receiving LTSS. This policy would assume Medicaid beneficiaries should receive HCBS unless institutional care is determined to be medically necessary or is chosen by the beneficiary. The fiscal direction and magnitude of the effect from Section 2.1 would require data not currently available, including a breakdown of utilization and expenditure by age and by HCBS versus institutional setting. This breakdown would not be currently available, in part because the Medicaid programs that provide LTSS also serve beneficiaries under age 55. Additionally, determining a fiscal impact would require data that reflects the extent to which the certification requirement in subsection (d) would change placement outcomes relative to current practice. DHHS did not provide data on the estimated costs of implementing Section 2.1 before this analysis was published.

Sections 2.2: Medication Review; 2.3: Behavioral Health Integration; 2.4: Social Isolation Screening

These sections direct DHHS to implement periodic medication reviews, integrate behavioral health services, and screen for social isolation among Medicaid beneficiaries aged 55 and older receiving LTSS. To project fiscal impacts from Sections 2.2, 2.3, and 2.4 would require data not currently available. Each section would impose a new or expanded administrative or clinical requirement on LTSS delivery, and the cost of each would depend on the gap between the current practices of DHHS and what the section would require. Determining that gap would require consideration of DHHS's current practice for each requirement, including review frequency and reviewer qualifications for Section 2.2, the extent of existing behavioral health integration for Section 2.3, and existing isolation screening practice for Section 2.4; the population subject to each requirement; and DHHS's approach to implementation. All three sections would grant DHHS discretion over implementation and would permit a phased rollout, affecting both the size and timing of any cost. DHHS did not provide data on the estimated costs of implementing these sections before this analysis was published.

Part III

Section 3.1: Integrated Senior Housing and Care Pilot Program

This section directs DHHS to establish and operate a pilot program that would integrate medical and behavioral health, pharmacy, and rehabilitative and support services into a residential facility for older adults who are dually eligible for Medicare and Medicaid. DHHS is directed to contract with an entity for the construction of a facility containing no more than 300 residential units. This

section appropriates $120 million nonrecurring from the General Fund for FY 2026-27 for both start-up and operating costs and directs that the funds shall not revert and that the pilot program will terminate when these funds are fully expended. Furthermore, DHHS is directed to structure this pilot program as a public-private partnership and acquire additional funding from sources such as the federal government, other public sector grants, and loans.

Section 3.2: Strengthening the Long-Term Care Ombudsman Program
This section directs the Division of Aging, within DHHS, to develop and implement a plan to address the vacancies and workload in the Office of the State Long-Term Care Ombudsman to improve the efficacy, accessibility, and timeliness of the Office's services. As of August 31, 2026, all six positions within the Office of the State Long-Term Care Ombudsman were filled.

The plan shall also provide for training and programmatic and administrative support for State and regional ombudsman personnel. This section appropriates $3.5 million recurring from the General Fund to implement the plan, including hiring additional personnel, improving case management systems, supporting programmatic and administrative functions, and strengthening coordination with other entities involved in the protection of long-term care facility residents.

Section 3.3: Geriatric Workforce Pipeline and Direct Care Career Advancement Program
This section amends Article 3 of Chapter 143B of the General Statutes to establish a program aimed at increasing the supply, geographic distribution, retention, and advancement of workers in professions that provide health and support services to older adults in a variety of settings. This section directs DHHS to design and administer the program in consultation with education agencies and institutions and other relevant entities. This section appropriates $10 million recurring from the General Fund beginning in FY 2026-27 for this program, which can be used to establish career pathways, credentials, training, work-based learning opportunities, and recruitment and retention initiatives, including financial incentives, for workers serving older adults, as well as make recommendations for modernizing scope-of practice and supervision laws, rules, or requirements. DHHS is also directed to prioritize workforce investments that target service providers of certain high-need population groups, and credentials that are widely recognized by relevant employers and training institutions.

Section 3.4: Family Caregiver Support Stipend Pilot Program
Section 3.4 directs DHB to establish a family caregiver support stipend pilot program for eligible caregivers of Medicaid beneficiaries receiving LTSS and appropriates $13.5 million recurring and $750,000 nonrecurring from the General Fund to DHB in FY 2026-27 for this purpose. DHHS has latitude to adjust the stipend amount (within a maximum of $400) based on the projected number of recipients, ensuring spending stays within the provided appropriation. Implementation of the pilot program depends on federal approval of any required State Plan Amendment or waiver submissions to the Centers for Medicare and Medicaid Services, and the section creates no entitlement to a stipend absent that approval. This section would expire two years after it becomes law, which limits the appropriation to two fiscal years regardless of its recurring designation.

Part IV

Section 4.1: Reestablishment of Study Commission on Aging

This section re-creates the Aging Study Commission (Commission) to study and recommend legislative and policy changes for North Carolina to respond to the needs of its aging population. The Commission is required to submit a report of its findings and recommendations to the General Assembly by December 31, 2027. The Commission is to receive support from staff provided by the General Assembly's Legislative Services Office; existing staff can be utilized so additional appropriations are not needed.

TECHNICAL CONSIDERATIONS

Sections 2.1: Home- and Community-Based Services Presumption; 2.2: Medication Review; 2.3: Behavioral Health Integration; 2.4: Social Isolation Screening

Sections 2.1 through 2.4 each give DHHS discretion over implementation mechanisms, including rulemaking, clinical policy, or managed care contract amendment, and permit DHHS to prioritize implementation for individuals at highest risk of medication-related harm, behavioral health-related hospitalization, or institutional placement. This discretion affects both the timing and the magnitude of cost, as first-year costs under a phased rollout would differ from steady-state costs at full population coverage. To the extent current infrastructure and staffing already meet the requirements of these sections, initial cost could be minimal or zero. Actual expenditure would likely begin at this lower range and grow over time as implementation expands, with the size of that growth dependent on demand for services beyond current capacity.

LTSS is comprised of multiple Medicaid programs and waivers, some of which also serve populations and needs unrelated to LTSS. Early confirmation of which specific programs and populations fall within the scope of Sections 2.1 through 2.4 would support both the data collection and the population estimates needed to assess this section's fiscal impact.

Section 3.1: Integrated Senior Housing and Care Pilot Program

This section appropriates $120 million to DHHS for the construction of a residential facility integrating medical and behavioral health, pharmacy, and rehabilitative and support services for older adults who are dually eligible for Medicare and Medicaid. The bill does not specify a minimum number of beds the facility must house, which allows DHHS latitude to adjust the capacity of the facility to fit the pilot program's budget. This analysis assumes that the provided appropriation will fully support all capital and start-up costs. While it is unclear exactly how many beds the appropriation will support in such a facility, reasonable comparisons can be made to Broughton Hospital, a State-operated psychiatric hospital in Morganton, North Carolina. Broughton Hospital opened in 2019 with a capacity of over 275 patients, and capital costs for the facility totaled approximately $175 million. Broughton Hospital is not a perfect proxy, as construction costs have increased significantly since 2019 and a psychiatric hospital may require complex and specialized features. However, this example shows that opening a facility of some magnitude for $120 million is feasible, though likely with fewer than 275 beds.

This section does not appropriate recurring funds to cover operating costs for the facility. This analysis assumes that Medicare and Medicaid reimbursements will generate sufficient receipts to

cover operating expenses for the facility. A similar situation exists within DHHS at the Division of State Operated Healthcare Facilities, where three neuro-medical facilities are Medicaid-certified skilled nursing facilities and largely cover their own operating costs with receipts from Medicaid, with their revenues sometimes outpacing expenses. However, future changes to Medicare or Medicaid reimbursement rates or eligibility could necessitate a recurring appropriation from the General Fund to cover operating costs for the facility.

DATA SOURCES

NC MEDICAID, DHHS
10A NCAC 22G .0109, NURSING HOME PROVIDER ASSESSMENT; NORTH CAROLINA ADMINISTRATIVE CODE
NORTH CAROLINA STUDY COMMISSION ON AGING, REPORT TO THE GOVERNOR AND THE 2007 REGULAR SESSION OF THE 2007 GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE – PURPOSE AND LIMITATIONS

This document is an official fiscal analysis prepared pursuant to Chapter 120 of the General Statutes and rules adopted by the Senate and House of Representatives. The estimates in this analysis are based on the data, assumptions, and methodology described in the Fiscal Analysis section of this document. This document only addresses sections of the bill that have projected direct fiscal impacts on State or local governments and does not address sections that have no projected fiscal impacts.

CONTACT INFORMATION

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