

POLICY FORUM: INVITED COMMENTARIES & SIDEBARS

The (Cross)road Less Traveled: NC Medicaid Steps into an Uncertain Future

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After the long road to expansion, NC Medicaid now faces unprecedented challenges from deep cuts and programmatic changes at the federal level, threatening access to care across the state. However, despite this new reality, opportunities remain for our health care ecosystem and policymakers to develop a more sustainable path forward.

Introduction

It's been just 2 years since landmark legislation was passed by the North Carolina General Assembly (NCGA) to expand Medicaid in North Carolina, with expansion formally taking effect in December 2023. The journey has not been without hiccups and growing pains, but today, expansion has led to more than 685,000 additional people being added to the rolls of NC Medicaid, which in total covers more than 3 million children and adults statewide.^{1,2}

However, the hard fought, bipartisan celebration may be relatively short-lived because of looming federal Medicaid program changes passed by Congress this summer. There is no single provision among those changes that would immediately threaten expansion in North Carolina, but new federal restrictions and cuts will present NC Medicaid, its beneficiaries, providers, hospitals, and communities with unanticipated and unprecedented challenges without the benefit of the same-sized safety net.

The future is never certain, but Medicaid in North Carolina is approaching a critical crossroads, and the next collective steps taken will determine how we best prepare and develop a sustainable pathway into the unknown.

Roots of Expansion

The NCGA's adoption of House Bill 76 in the spring of 2023 was the culmination of years of advocacy and bipartisan efforts to make Medicaid expansion a reality in North Carolina—and our state is the most recent in the country to do so.³

Prior to choosing expansion once the option became a possibility through the passage of the Affordable Care Act (ACA) by Congress in 2011, the NCGA made other relatively recent changes to the structure of NC Medicaid, including the adoption of legislation in 2015 that authorized the transition from a more traditional fee-for-service system to one of managed care.⁴ Due to implementation and legal challenges, the managed care system would not take effect until July 1, 2021. Managed care arrangements allow states to contract with private companies called Managed Care Organizations (MCOs) to provide Medicaid benefits and services to enrollees for a set monthly payment. The managed care model aims to better control costs, service utilization, and improve health outcomes and care coordination through a contracted network of providers rather than a potential patchwork community of providers that may more freely opt in and out of participating in fee-for-service. Managed care has generated savings as expected, but recent estimates suggest its relative cost of providing contracted services may slightly exceed any net revenue benefit.⁵

Because we are in a managed care environment, expansion allowed for the establishment of North Carolina's state-directed payment program (SDP). SDPs authorize state Medicaid programs to direct their MCOs to make payments to health care providers to meet stated policy goals. In North Carolina, our SDP is known as the Healthcare Access and Stabilization Program (HASP). HASP was designed specifically to bridge the gap between standard Medicaid reimbursement rates and the actual cost of care, support providers in critical need and utilization areas, and to be used to maximize value-based initiatives and incentives.

HASP accomplishes this goal in part through the utilization of provider taxes. Provider taxes, which have been around since the 1980s and were more formally defined and regulated by the federal government beginning in 1991, help states fund their Medicaid programs through assessments and fees imposed on hospitals, providers, and MCOs.⁶ The provider tax arrangement in North Carolina is especially important because of the federal-state matching formula for expansion populations. While the federal government covers 90% of the cost of administering Medicaid, states are responsible for the remaining 10%. As part of the agreement to ensure that expansion efforts were successful in North Carolina, hospitals agreed to essentially cover the full cost of the state's share through assessment taxes. In fact, underlying legislation does not otherwise allow for any general funds to be used for expansion purposes, otherwise an immediate unwinding of Medicaid expansion would be triggered. Provider taxes, in total, are capped at 6% of net patient revenue—but the more they are effectively utilized under that cap, the more federal dollars under the SDP arrangement the state, through HASP, can draw down to support Medicaid and other service and access priorities in North Carolina.

The same as any other state, North Carolina's SDP and provider tax structure is subject to annual approval by the federal Centers for Medicare & Medicaid Services (CMS). The state submits a preprint with more detailed information and any planned or requested changes to its Medicaid program before it is eligible to receive rate benefits associated with expansion. CMS has previously allowed NC Medicaid to reimburse providers at average commercial rates (ACR), which are higher than those traditionally paid for government-sponsored health care plans.

The final implementation of HASP was subject to an additional condition imposed by the administration of then-Governor Roy Cooper and supported by the Biden administration. All 99 eligible North Carolina hospitals agreed to participate in a medical debt mitigation program in order to receive full HASP-related payments.^{7,8} The program requires forgiveness of certain medical debt for low-income and Medicaid beneficiaries, more prominent charity care policies, and programs addressing financial assistance. It has been recently reported that the effort has resulted in over \$4 billion in medical debt savings for patients and families. Fortunately, many North Carolina hospitals had already adopted strong charity care and financial assistance policies prior to the issuance of the directive by the Cooper administration and approval by CMS. However, the agreement was also undertaken with the anticipation that HASP would remain a viable option to maximize federal support for Medicaid.

Medicaid Today: A Snapshot

As noted, expansion has led to coverage for over 685,000 additional people across North Carolina.⁹ Of the current total Medicaid population, 43% are children, 26% live in rural designated communities, and 18% have chronic conditions.¹⁰ Approximately 56% are female and 44% are male. Fifty-six percent identify as White, 37% as Black, just over 16% as Hispanic/Latino, and roughly 2% as Asian.¹¹

In state fiscal year 2024, NC Medicaid spending across all funding sources reached \$27.79 billion.¹² Nearly \$26.5 billion of that spending went directly to beneficiaries, supporting patient care through claims, premiums, HASP, expansion-related growth, and supplemental payments from hospitals. Administrative costs only accounted for approximately 2.5% of all Medicaid spending.

The new provider tax structure allowed the state to receive \$7.1 billion in federal support in exchange for hospitals contributing \$1.4 billion in taxes and assessments. This \$1.4 billion included¹²:

- \$359 million of the state's cost for Medicaid expansion.

- \$24 million to provide Medicaid coverage for postpartum women for up to one year after the birth of their baby.
- \$63 million in Graduate Medical Education to train the next generation of doctors and strengthen the state's health care workforce.
- \$140 million to support wages for state-directed care workers who provide home and community-based services.
- \$159 million to reinvest in health care priorities across North Carolina (\$43 million of which is for Medicaid expansion retention).
- \$690 million to support Medicaid base rates.

Expansion and the benefit of HASP have brought Medicaid service revenue closer to the true costs of care and have allowed North Carolina hospitals to expand services and increase access in communities despite geographic limitations through innovations and investments in new technology. Some systems began capital improvement planning to update physical infrastructure and provide additional specialized care.

State Medicaid Rebase Challenges

The present reality of Medicaid in North Carolina is also characterized by an impasse at the NCGA over funding the Medicaid rebase for state fiscal year 2026. The amount initially allocated by the legislature in a mini budget in late June 2025 was deemed insufficient by the North Carolina Department of Health and Human Services (NCDHHS), and the department announced plans to begin cutting rates on October 1, 2025, if the legislature could not come to an agreement on additional funding closer to NCDHHS's projected needs. Both chambers of the NCGA have agreed on the need for additional funding, but unrelated matters have kept a final deal from coming together at the end of this year.

NCDHHS began preparing to implement rate cuts on varying provider types at 3%, 8%, and 10%. The highest of the rate cuts would be applied to hospitals. NCDHHS is in the process of submitting a formal request to CMS to implement those changes before the governor announced a reversal in early December.¹³ While the state plans to restore reimbursement rates to pre-cut levels, there still is no longer-term funding solution. It is possible that the issue may languish for several more months until the NCGA reconvenes for a short session next spring.

The era of expansion had otherwise seemed like the beginning of a new renaissance in patient access and care opportunities in North Carolina. But by early 2025, a much harsher possibility was coming into focus. With the aid

of a partisan legislative tool, some influential members of Congress saw the opportunity to drastically scale back federal spending in health care through Medicaid as a way to offset the costs of other priorities.

Current events between the state legislature and NCDHHS only further highlight the fragility of this complex and vitally important system.

Projecting the Future of NC Medicaid

The passage of the 119th Congress' House Resolution 1 (HR1), "the One Big Beautiful Bill Act," now officially titled Public Law 119–21, in July through the purposely partisan budget reconciliation process in Congress sent shockwaves for state-administered Medicaid programs across the country. HR1 was messaged publicly as comprehensive legislation to address the Trump administration's tax, immigration, and national security agenda—and the White House and many lawmakers said publicly in the early stages of the debate that they did not want the effort to become health care-focused. Yet after nearly 7 months of process, disagreements, and quickly organized final votes, the public focus was mostly on the over \$900 million in cuts to the federal Medicaid program designed to help offset the cost of implementing many of the other priorities.

While the direct financial impact of many of these policy changes will not be felt immediately, the progress made by NC Medicaid in the first 2 years of the expansion era will face headwinds and challenges over the next decade and perhaps beyond as the program adapts to a new normal with reduced federal support, stricter eligibility requirements, and greater burden on state-based infrastructure. Hospitals are already preparing now for reductions in federal support, as well as the likelihood that additional resources for program and capital investments will not be as plentiful.

Provider Taxes

As noted, the hospital assessment tax and other related taxes collected from the health care provider community are responsible for expanded access to health care services for Medicaid beneficiaries. Maximizing such a provider tax structure with a ceiling of 6% of net patient revenue has meant that hospitals have the ability to access additional federal dollars to bolster other health care priorities and seek improvements.

HR1 gradually restricts the establishment of new provider taxes immediately and gradually phases down the 6% threshold, beginning October 1, 2027, by 0.5% per year until settling at a new cap of 3.5% on October 1, 2031.¹² Practically, this reduction means that North Carolina and its hospitals will lose the benefit of HASP, resulting in a loss of an estimated \$32 billion in federal support over 10 years.

The reduced threshold will also likely result in the NCGA making difficult decisions over time to decide what services its remaining allowable percentage of provider taxes can support. With expansion costs and the state share of Medicaid, provider taxes already account for around 4% of the net patient revenue threshold. Because maintaining and protecting expansion will likely be the highest priority, current taxes supporting GME, postpartum coverage, home- and community-based services, and mental health services may be in jeopardy of facing reductions or being eliminated entirely over time.

The new law also prohibits expansion states such as ours from imposing any new provider taxes that were not already in consideration for approval by CMS after July 4, 2025.¹⁴ The flexibility to respond to emerging needs for the state's Medicaid population through provider assessments is no longer a permissible option. The loss in federal support also places a greater onus on the state to make up for financial gaps that could impact service availability and access. It is responsibility that no state or commonwealth is prepared to shoulder alone without massive and potentially disruptive changes to their Medicaid infrastructures.

State Directed Payment Programs

HR1 restricts the rates that state-directed payment programs are allowed to reimburse for Medicaid services. HASP has been critical for stabilizing hospitals and expanding access to care, but even if no changes were made to the existing provider tax structure as previously outlined, this rate change provision would have the same effect in eliminating the value and purpose of our SDP in North Carolina. While CMS guidance suggests that the state's most recent preprint authorizing HASP rates, which are currently reimbursed at ACR, is temporarily "grandfathered" in, the rates will begin to phase down by 10% per year beginning on July 1, 2028, until the rates are no higher than that of 100% of Medicare.¹⁵

Medicare rates historically reimburse less than actual costs of care and certainly less than the present value of Medicaid reimbursement. Will hospitals and providers be able to continue to see the same high volume of Medicaid patients if there are uncertainties about the cost of care being under-supported? Hospitals will never turn away patients in need, but investments in facilities, equipment, and services for all patients will face new financial and structural challenges.

These rate reductions may be even more acutely felt by those who serve underserved, rural, and certain urban communities that have a higher percentage of Medicaid patients. Access is the primary concern, and despite intensive planning efforts underway right now to begin preparing for impending financial changes, it is nearly impossible to predict what decisions

will need to be made to preserve quality care and support operations over the next few years as implementation of this policy, in combination with provider tax restrictions, begins.

Together, the phased-in reductions of the provider tax cap and SDP rates were among the biggest sources of revenue to help offset the cost of HR1, but removing their associated costs and financial responsibility from the federal ledger did not negate them entirely. They've just been transferred much closer to home.

Medicaid Work & Community Engagement Requirements and Redeterminations

The law requires the implementation of state-administered community engagement requirements to maintain Medicaid program coverage eligibility for expansion population adults aged 19–64 who do not otherwise meet exemption criteria, including those who are disabled, face mitigating medical challenges, parents of children aged 13 and under, and pregnant and postpartum persons.¹⁶

Those adults who are determined to not be exempt must have paid employment, be engaged in specified job training or placement programs, participate in community service, or be enrolled in an education program for at least 80 hours per month. The new requirements are coupled with a supporting provision that now requires states to conduct eligibility determinations twice per year. North Carolina and other expansion states must have a CMS-reviewed plan ready to implement within the first quarter after December 31, 2026.

At the moment, there are clear statutory requirements but only broad federal guidance.¹⁷ The interim final rule (IFR), which will likely contain more definitive information on requirement guidelines and timelines, is not due for release until June 1, 2026. There is every expectation that more information will be publicly issued before that deadline, but it is not guaranteed, and North Carolina may have only a tight 6-month window in which to ensure its program is fully compliant with federal directives.

Like many states, North Carolina relies heavily on county-level assistance through local Divisions of Social Services (DSS) to administer its Medicaid program. The impending changes are very likely to increase their workload, resulting in potential paperwork and processing delays, along with massive compliance education efforts for Medicaid beneficiaries across the state and DSS office workforce capacity challenges. Some estimates project as many as 255,000 North Carolinian Medicaid adult beneficiaries may lose coverage due to the imposition of the new requirements, but that number is likely more reflective of potential administrative challenges than a strict lack of compliance.¹⁸

HR1 authorizes \$200 million to assist states with implementation, but that final guidance for precisely when the funds will be distributed among the states also remains outstanding, outside of assurances that it will be available in FY 2026. How North Carolina will address these previously unanticipated additional administrative costs in both the short and longer term to support programmatic changes that primarily affect the expansion population is an open question.

While the underlying expansion statute restricts the use of general funds for expansion-related expenses, otherwise triggering its unwinding, the reality of the needed expenditures to implement the new requirements is much more complicated. Notably, state law does have some existing options to consider that would not otherwise force the NCGA to amend the current hospital assessment tax language to include costs associated with work requirements. Expected program savings achieved through expansion may be eligible for consideration as a funding source.¹⁹ Changes to how the percentages for existing taxes on plan premiums are applied as a revenue source for the Medicaid program may also offer an additional funding alternative.²⁰ The hospital community, NCDHHS, and the NCGA are engaged in conversations about the most sustainable path forward.

Other Selected Eligibility & Access Changes and Provider Realities

HR1's Medicaid provisions also make more targeted changes to eligibility and access requirements for certain populations, which may result in coverage losses for additional traditional and expansion beneficiaries. On October 1, 2026, the definition of legal immigrants who are eligible for Medicaid or Children's Health Insurance Plan (CHIP) coverage is restricted to lawful permanent residents, certain Cuban and Haitian immigrants, citizens of the Freely Associated States (COFA migrants) lawfully residing in the United States, and lawfully residing children and pregnant adults in states such as North Carolina that cover them under the Immigrant Children's Health Improvement Act (ICHIA) option.²¹ Also of note, there is a limitation on retroactive coverage to 1 month from 3 months beginning on January 1, 2027.²²

Reductions in payments and potential coverage losses don't just impact Medicaid beneficiaries. The prospect of fewer insured patients combined with decreases to the reimbursements that cover the cost of Medicaid recipients' care means hospitals have fewer resources for specialty services. As discussed, rural and underinvested communities face the risk of reduced services and local access issues. Hospitals throughout the state may consider scaling back or pausing some programs or services to continue providing essential care.

Cuts to Medicaid may appear as budget savings on paper, but the real cost is delayed treatments, lost access to care, and increased strain on families, employers, and taxpayers. Health insurance coverage may not be legally required, but eventually everyone will have an emergent health care need. Patients continue to get sick regardless of coverage, and the financial burden shifts to hospitals, patients, and the broader community.

Rural Health Transformation Fund

The Rural Health Transformation Fund (RHTF) was a late addition to HR1, created in part to assuage concerns and garner broader legislative support from certain members who expressed concerns about the deep Medicaid cuts that would impact their rural constituents. The RHTF, which is a temporary grant program, was not created with the expectation or intent of making up for the financial losses states will incur as a result of other Medicaid program changes, but rather as a bridge for states to support the establishment of more streamlined access for patients and innovations in care delivery.

The 50-billion-dollar program, directed and administered by CMS, will provide grants directly to states to support rural health care and statewide health care system improvements.²³ Fifty percent of funds will be distributed equally across all states with approved plans. The other 50% will be distributed, at CMS's discretion, based on the individual state's rural metrics, including its rural population, number of rural facilities, number hospitals serving low-income patients, quality of the state's initial application progress towards planned initiatives, and the addressing of state policy changes favored by the administration (such as the elimination of Certificate of Need (CON) laws, scope of practice changes, and SNAP waivers). States are permitted to use up to 10% of allocated funds for administrative costs. North Carolina may be eligible for at least \$200 million per year over the 5-year duration of the program.

The application process for the RHTF officially opened in September, with states required to submit applications by November 5, 2025, with the expectation that CMS will make approval decisions by December 31, 2026.²⁴ States that qualify for funding will then be responsible for providing annual updates to CMS, and the quality of the work undertaken with the awarded funds will be used to assess and determine the amount of funding over the remaining 4 years.

The parameters of the grant program are relatively clear, but the actual benefit to North Carolina is yet another question highly dependent on variables that may be outside of the influence of those who contributed to and submitted the application. In reality, despite how the RHTF was first pitched to members of Congress seeking relief for their rural communities in HR1, direct support for rural health care and providers may fall short

of those expectations. States are not legally required to direct any of the funds to rural hospitals, and there are limitations on how much can be allocated directly to providers, as well as for capital investments. NCDHHS has indicated it intends to outline its process for providers to apply for funds in early 2026 after awards are announced to maximize potential resources; however, even in the best-case scenario, it's unclear how much of the funding will directly flow to meet urgent, on-site needs.

North Carolina has the second-largest rural population in the country, with higher chronic disease rates, and is under threat for possible rural hospital closures due to dwindling federal support. Supporting such a population and working to improve health care outcomes can only be achieved through collaboration and significant, targeted investments. To be fair, the RHTF was never branded as the solution to nationwide rural health concerns that accompanied the broader Medicaid cuts in HR1. The creation of the program does seem to be an acknowledgement that serious resourcing and access challenges are currently affecting and may continue to plague rural communities, in part because of legislative and regulatory changes. Opportunities do exist within the RHTF for at least some shorter-term stabilization, but longer-term solutions require ongoing commitment and conversation.

Two Steps Back, What's Forward?

It's important to reiterate that many of the changes to Medicaid have not yet taken place—and all legislation and regulatory efforts, no matter how entrenched they may seem from a policy or political perspective, are potentially reversible. The best method to root out and expose potential darker outcomes is to expose those possibilities to sunlight. Advocacy is at the core of our mission at the North Carolina Healthcare Association—but we do not shoulder that responsibility alone.

We remain engaged with our congressional delegation, encouraging our members to tell their stories and share how expansion and pre-HR1 Medicaid has benefited care access opportunities and improved quality for patients across the state regardless of geographic location or who pays for the services.

If you share concerns about the future of Medicaid in North Carolina, your voice and uplifting those perspectives from your communities served is one of the most engaging and powerful tools at your disposal. It will not be easy. It will not be quick—and it must also be accompanied by thoughtful and reflective feedback and a willingness to reach alternative solutions. If we are unable to fully reverse but merely delay harmful policy changes, what do we do with the time in between? How do we keep building a new and different path forward when the possibility of some predetermined outcome stares right back at us with every step?

We keep moving. We share the truths of our experiences and remember that our bottom line is and has always been support for our workforce, our patients, our communities, and the mere possibility of better outcomes and experiences, because we direct our focus and resources to not just what is probable in the moment in which we are grounded but also beyond our present limits to conceive for tomorrow.

For NC Medicaid to thrive, advocacy and education are not optional. They are foundational. So, take that step forward. You won't be alone.

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Declaration of interests

The author is a registered NC state lobbyist for NCHA.

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