





North Carolina Department of Health and Human Services (NCDHHS) Medicaid Assessment

Report

November 20, 2026

Executive Summary



Context

- Medicaid is critically important to North Carolina, providing health care to over 3 million people and contributing $30 billion to the state's workforce and economy.
- Medicaid is not immune to increasing health care costs in the state and nation, and H.R. 1, the "One Big Beautiful Bill Act" (OBBA), will further compound Medicaid cost pressures.



Project Purpose

- The purpose of the assessment is to identify strategic, data-informed strengths and opportunities for North Carolina to enhance the outcomes, value, efficiency, and long-term sustainability of Medicaid.
- NCDHHS is proactively undertaking this assessment as a part of its commitment to the health of North Carolinians and in anticipation of federal funding reductions under H.R. 1.
- The assessment fulfills Section 3C.14 of House Bill 696.



Key Findings

- North Carolina's *total Medicaid spending*—as a program and per enrollee—has grown substantially in recent years, while North Carolina's Medicaid spending *as a share of general fund* has remained flat. *Per enrollee spending* remains below most Peer States and the national average.
- There is significant variation in costs, rates of cost growth, and outcomes across Medicaid service lines and populations, including: hospital services, long term services and supports (LTSS), primary care and population health, behavioral health, research-based behavioral health treatment (RB-BHT), prescription drugs, managed care, and administration and state operations.
- North Carolina identified 27 program and policy actions that can improve value, outcomes, and/or efficiency in Medicaid in these opportunity areas.

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I. North Carolina Medicaid Assessment Project Overview

I.a. Context: The Big Picture

Medicaid is Critically Important to North Carolinians

Medicaid provides health care to over three million North Carolinians, including:



1 in 4 North Carolinians



2 of every 5 children



50% of all births



5 in 8 people in nursing facilities



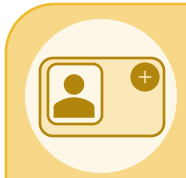
3 in 10 people with disabilities

Medicaid Strengthens North Carolina



Medicaid Fuels North Carolina's Workforce & Economy

- North Carolina Medicaid contributes **$30 billion to North Carolina's economy**.
- **92% of people with Medicaid in North Carolina have documentation demonstrating they are working**, or are in school, disabled, or caregivers.



Medicaid Expansion Makes Care Accessible

- **North Carolina's uninsurance rate has dropped** from 11.3% to 8.6% since expansion, which covers more than 730,000 North Carolinians.
- Since expansion, **more behavioral health providers are serving people covered by Medicaid** (17% increase) and **emergency department visits for overdose and suspected overdose deaths are down** (29% and 27%, respectively, between 2023 and 2024).



Medicaid Is Vital for Rural North Carolinians

- **Rural residents are more likely to have Medicaid coverage** (35% of the state's population and 39% of Medicaid enrollees).
  - Over 250,000 individuals in rural areas have coverage under Medicaid expansion.
- **Medicaid supports rural and safety net hospitals** by reducing the burden of uncompensated care.

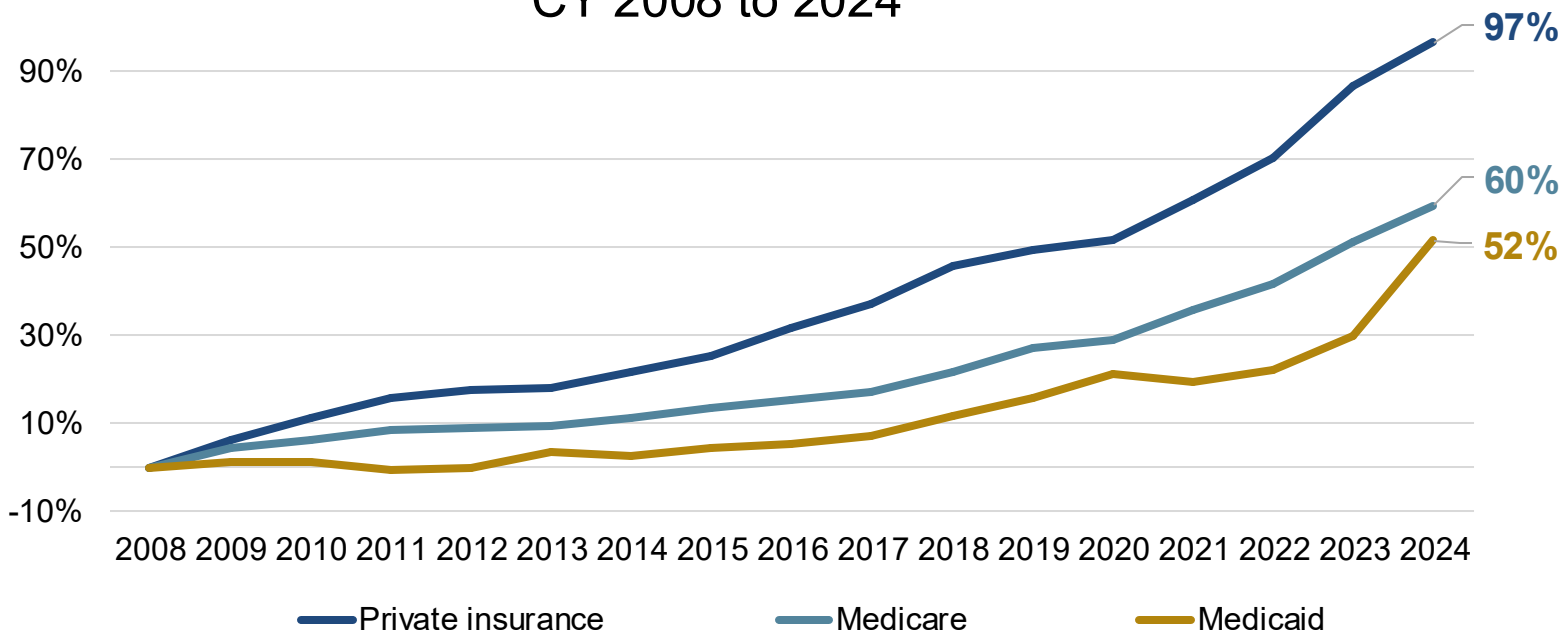
Medicaid Is Not Immune From Health Care Cost Growth Pressures

Americans in every state are facing high and growing health care costs.

Key National Factors

- **Health care is expensive and costs are growing.** This is not specific to Medicaid—it is true across all states and all coverage types.
- While **Medicaid has grown at less than half the rate of private insurance**, the rate of growth ticked up in recent years.

Nationwide Growth in Health Care Spending per Enrollee Relative to CY 2008
CY 2008 to 2024



Notes: CY = Calendar Year. Eligibility groups based on MACPAC approach for summing full year equivalent enrollees by eligibility group.

Sources: CMS, National Health Expenditure Data; Peterson- KFF, KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data; KFF Health System Tracker, Health System Dashboard; MACPAC, MACStats Exhibit 21, Medicaid Spending by Eligibility Group;

Medicaid Programs Nationwide Are Facing New Pressures



Medicaid enrollee costs have been increasing for several reasons, including:

- **Payment rate increases** introduced during the COVID-19 public health emergency (PHE) have become permanent.
- **Population need has shifted due to the end of the COVID-19 PHE**—those who retained Medicaid coverage after "unwind" are older and have more medical needs.
- **An aging population** across the country is causing the demand for cost- and resource-intensive services to increase.
- **Costs for labor, medical supplies, prescription drugs, and health care inflation are increasing** nationwide.



Federally mandated changes will strain Medicaid, including program eligibility, operations, and funding.

- North Carolina was able to stretch General Fund dollars further using temporary, enhanced federal match rates for COVID and new Expansion states. **Both enhanced match rates have sunset**.
- H.R. 1's coverage and financing requirements will **increase per-member and administrative costs while further reducing federal funding** for the Medicaid program.

Estimates of H.R. 1 Impacts on North Carolina Medicaid

- More than 250,000 North Carolinians are at risk of losing coverage.
- H.R.1 is estimated to reduce Medicaid funding to North Carolina by as much as $50 billion over the next decade.

Source(s): CMS National Health Expenditures; KFF, Medicaid Coverage for People Ages 50 and Older; US Census Bureau, 2023 National Population Projections Tables; CBO, Medicaid-Related Provisions in Title IV of H.R. 1.; 2025.07.02 HR 1 NC Governor Letter to US House.pdf; June 6, 2025: Governor Stein's letter to Senators Tillis and Budd on the U.S. House's Budget Reconciliation Bill | NC Governor

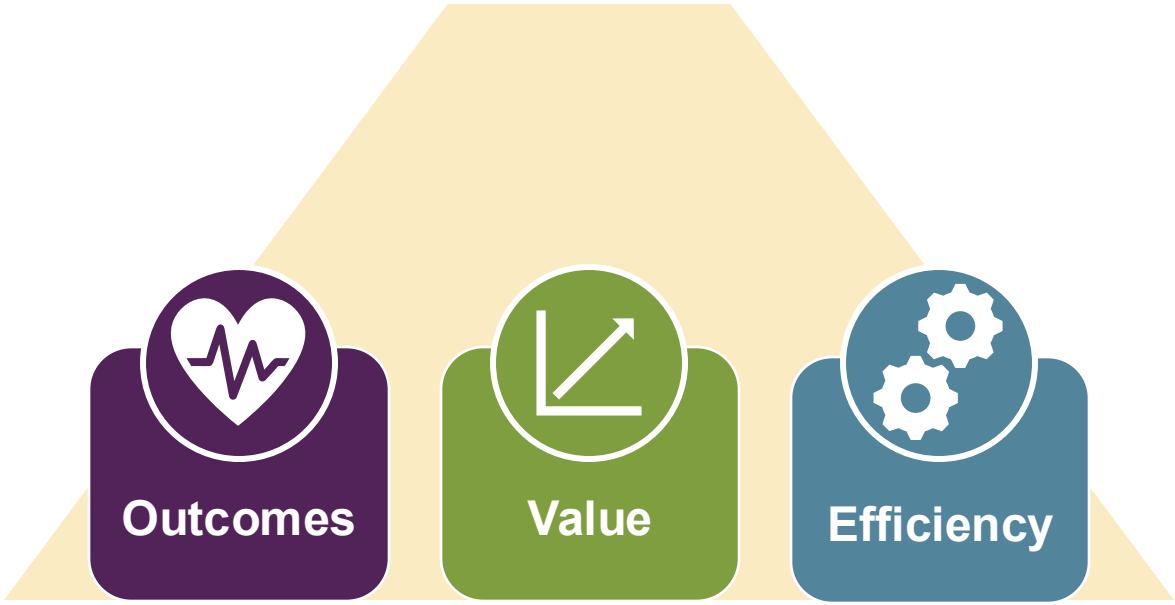
I.b. Project Purpose and Approach

NC Medicaid Assessment Purpose: Strengthen Medicaid

Project Goal

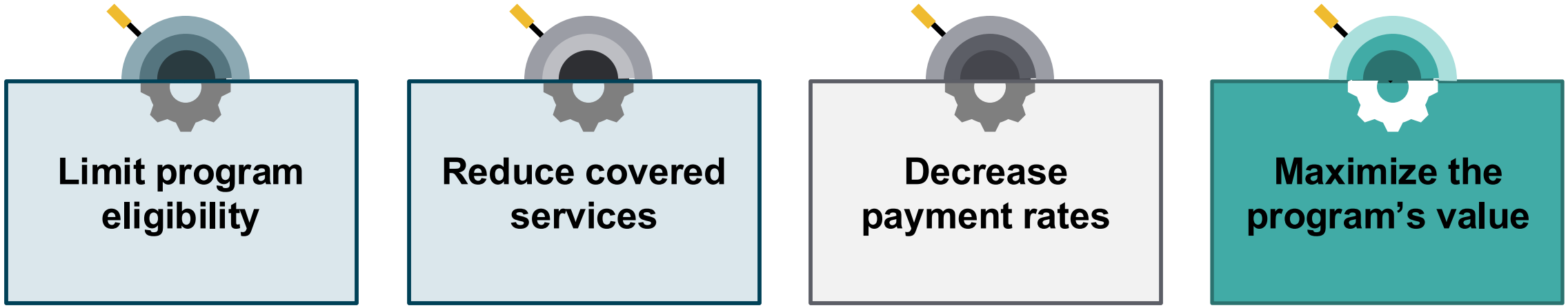
- The purpose of the assessment is to identify strategic, data-informed strengths and opportunities for North Carolina to **enhance the outcomes, value, efficiency, and long-term sustainability of Medicaid**.
- NCDHHS is proactively undertaking this assessment as a part of its **commitment to the health of North Carolinians**.

NCDHHS is focusing on identifying opportunities to enhance:



Focusing on Value

States have four major levers to manage Medicaid costs and produce savings:



Objective: Maximize Value, Outcomes, and Efficiency

While there is no magic bullet to contain Medicaid costs, states can take more nuanced, but also more complex, actions to maximize program value while producing savings.

NC Medicaid Assessment Approach: Data Driven, Stakeholder Informed

Landscape analysis to identify NC Medicaid cost drivers and opportunities for enhanced outcomes, value, and efficiency

Identification and proposal of **policy and program actions** to address opportunity areas

Report outlining assessment **findings** and **implementation considerations**

Future focus: **Action prioritization and implementation**

Stakeholder Engagement (Refer to slide 14)

The North Carolina Medicaid Assessment also addresses the requirements outlined in Section 3C.14 of House Bill 696 (Refer to slide 15 for more information)

Stakeholder Engagement Snapshot

Stakeholders were engaged throughout the North Carolina Medicaid Assessment, and their input on the analysis and policy and program actions is integrated into this report, which is open for public comment now.

Stakeholder Engagement Snapshot

Assessment **engaged a wide range of stakeholders**, including:

- Advocates and Medicaid enrollees
- Health care providers and associations
- Health plans

- **Two webinars drew 158 and 130 attendees** to learn more about the North Carolina Medicaid Assessment, Landscape Analysis findings, and Policy and Program Actions.
- NCDHHS received 31 form responses and written comments from 7 organizations.

Webinars and Feedback Collection

- **Webinars**:
  - Sep. 3, 2026: Project Overview & Landscape Analysis
  - Oct. 2, 2026: Policy & Program Actions
  - Oct. 13 – Nov. 9, 2026: Small Group Stakeholder Discussions
- **Feedback Collection:**
  - During each webinar, NCDHHS responded to stakeholder questions.
  - Following each webinar, stakeholders submitted feedback.
  - NCDHHS collected input during the group discussions.

Stakeholders are invited to provide public comment on this report here - through December 21, 2026

Addressing House Bill 696

The North Carolina Medicaid Assessment report fulfills the Section 3C.14 of House Bill 696 (H 696) requirement that North Carolina Medicaid submit a legislative report to address a plan for improved health outcomes, program integrity, cost savings, and efficiency in the Medicaid program.

Section 3C.14 H 696 Requirements

1. Reduction of DHB administrative expenses through streamlining or standardization of DHB functions
2. Increased flexibilities for prepaid health plans (PHPs) to manage service utilization and costs and align claims operations with national standards and best practices
3. Alignment of rate schedule for inpatient hospital and hospital lab services that can be provided in an outpatient setting where appropriate
4. Flexibilities for PHPs to manage utilization of glucagon-like peptide-1 (GLP-1) medications for weight loss
5. Improved alignment of Advanced Medical Home (AMH) and PHP contract incentives with PHP cost containment efforts
6. Improved reporting on AMH care management activities
7. Improved network management provider credentialing and certification tools for nonclinical providers

How Requirements Were Addressed

Landscape analysis

- Data was analyzed to inform development of H 696-related actions (e.g., NCDHHS administrative expenses from CMS-64 Reports).

Policy and Program Actions

- Actions that relate to each H 696 requirement were identified and evaluated (refer to Section III (proposed actions) and Section IV (other opportunities)).
- Throughout the report, this indicator refers to H 696 related actions: **H 696-related**

Stakeholder Engagement

- Stakeholder feedback on H 696-related actions was sought throughout this process.
  - Stakeholders are invited to provide additional feedback on the H 696-related actions through public comment.

II. Landscape Analysis Approach and Findings

II.a. Landscape Analysis Approach

Landscape Analysis Considered Cross-State and NC Data in Focus Areas

The assessment analyzed national and state data to identify opportunities to improve program outcomes, value, and efficiency.^

- **Cross-State Benchmarking Analyses**: used publicly available data to compare North Carolina Medicaid spending, enrollment, utilization, and outcomes to Peer States
  - Refer to slide 150 for more information about peer states.
- **North Carolina Cost Driver Analyses**: used North Carolina data to deepen and contextualize understanding of state Medicaid cost centers, cost drivers, and outcomes

Focus Areas	
Service Types	
Hospital Services	Primary Care and Population Health
Prescription Drugs	Behavioral Health
Long-Term Services and Supports (LTSS)	Research-based Behavioral Health Treatment (RB-BHT)
Delivery System Factors	
Administrative Services	
Managed Care	

^More details on methodology and data limitations can be found in the Appendix.

Focus Area Analysis Identifies NC Cost Centers and Cost Growth Drivers

Focus Area analyses sought to identify North Carolina Medicaid's primary cost centers and drivers and to benchmark spending and performance relative to Peer States.

Key Objectives

- **Analyze North Carolina Medicaid enrollment, utilization, spending, and outcomes in select Focus Areas**, identifying services with significant spending volume (e.g., cost centers) and growth (e.g., cost drivers).

Cost Centers	Cost Growth Drivers
Services that account for a disproportionate share of Medicaid spending	Services that account for a disproportionate share of Medicaid spending growth

- **Identify program service outliers**: Assess where North Carolina's Medicaid program diverges from Peer State and national trends.
- **Contextualize outliers**: Assess how trends (e.g., post-expansion enrollment growth) have impacted spending, utilization, and outcomes.
- **Target potential program actions**: Identify program areas that may warrant actions to improve value, outcomes, and efficiency in support of overall Medicaid program sustainability.

II.b. Statewide Trends

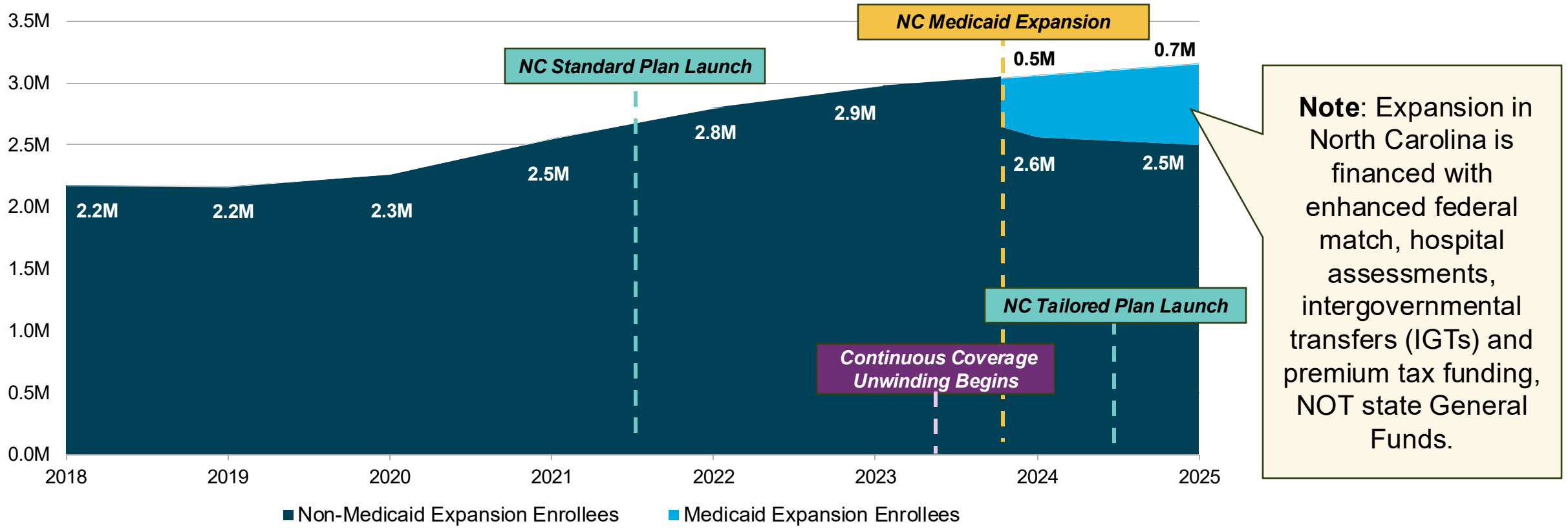
Landscape Analysis Overview

- **North Carolina Medicaid is not immune to increasing health care costs**. While Medicaid enrollee costs have grown at half the rate of private insurance, Medicaid confronts the same cost pressures for labor, medical supplies, prescription drugs, and health care inflation.
- **While North Carolina's *total Medicaid spending*—as a program and per enrollee—has grown substantially in recent years**:
  - **North Carolina's Medicaid spending *as a share of the general fund* has remained flat** and below that of most Peer States, despite covering an additional 700,000 people through Medicaid expansion. Expansion is funded by enhanced federal match, hospital assessments, and premium tax revenue.
  - **North Carolina's per enrollee spending remains below most Peer States and the national average**.
- **Reductions to the federal matching percentage since FY 2023 have recently shifted costs to the state**. Looking ahead, H.R. 1's cuts to state directed payments (SDP) and provider taxes could put additional pressure on the state General Fund.
- **North Carolina Medicaid—like all Medicaid programs—has opportunities to strengthen program value**.

Medicaid Enrollment Has Grown in North Carolina

North Carolina's recent Medicaid enrollment growth was driven by implementation of Medicaid expansion, with enrollment among non-expansion enrollees decreasing during Medicaid unwinding.

North Carolina Medicaid Expansion v. Non-Expansion Enrollment, CY 2018 to 2025



Note: Expansion in North Carolina is financed with enhanced federal match, hospital assessments, intergovernmental transfers (IGTs) and premium tax funding, NOT state General Funds.

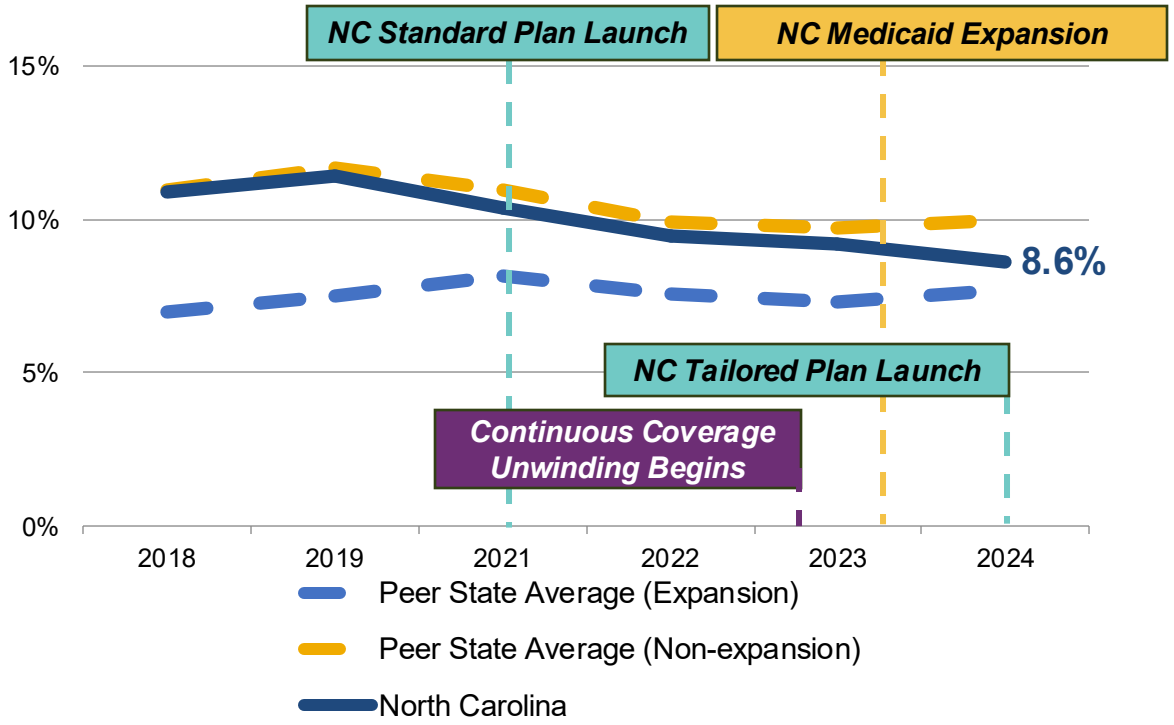
Notes: North Carolina expanded Medicaid in December 2023. Annual enrollment counts are annual averages of monthly counts and may undercount unique individuals. Enrollment counts do not include S-CHIP populations. CY = Calendar Year.

Source: CMS-64 Medicaid Budget and Expenditure System (MBES) reports.

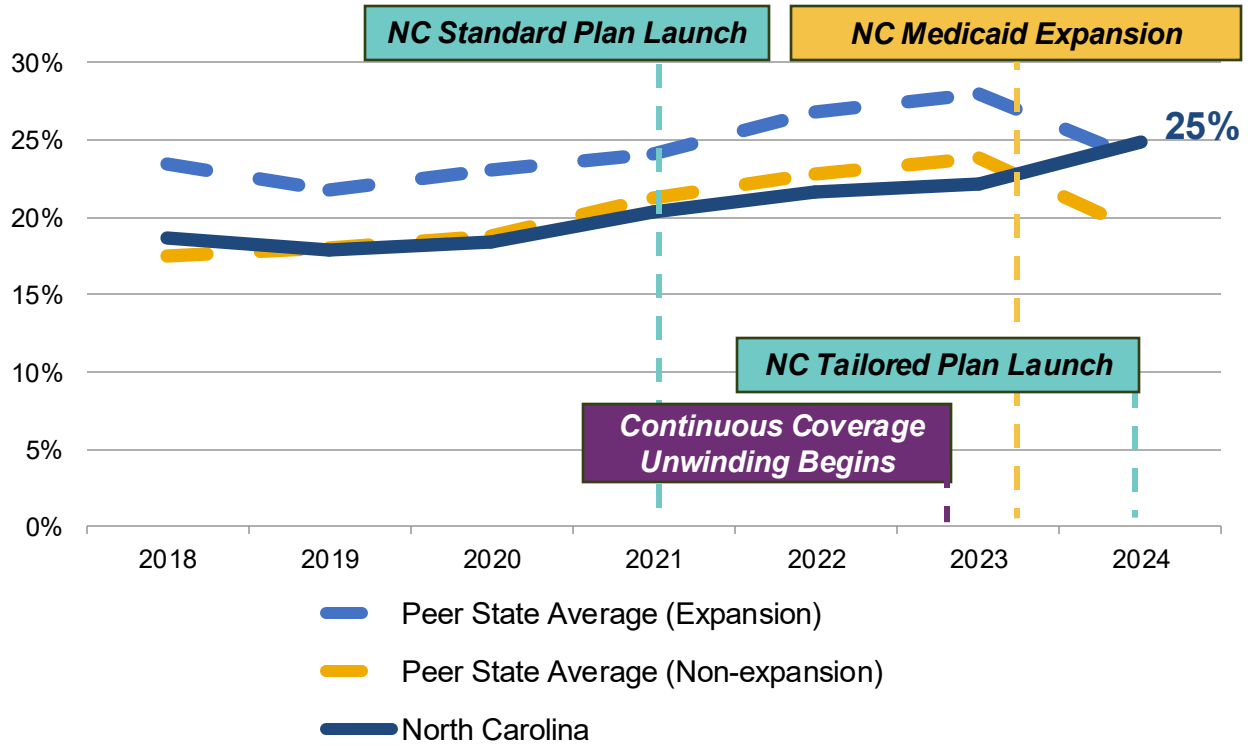
As Medicaid Enrollment Increased, Uninsurance Rates Have Gone Down

Following implementation of Medicaid expansion, the share of uninsured individuals in North Carolina decreased while the share enrolled in Medicaid increased, bringing North Carolina in line with Peer Expansion States.

Percentage of Individuals by State, CY 2018 to 2024



Percentage of Total State Population Enrolled in Medicaid, CY 2018 to CY 2024



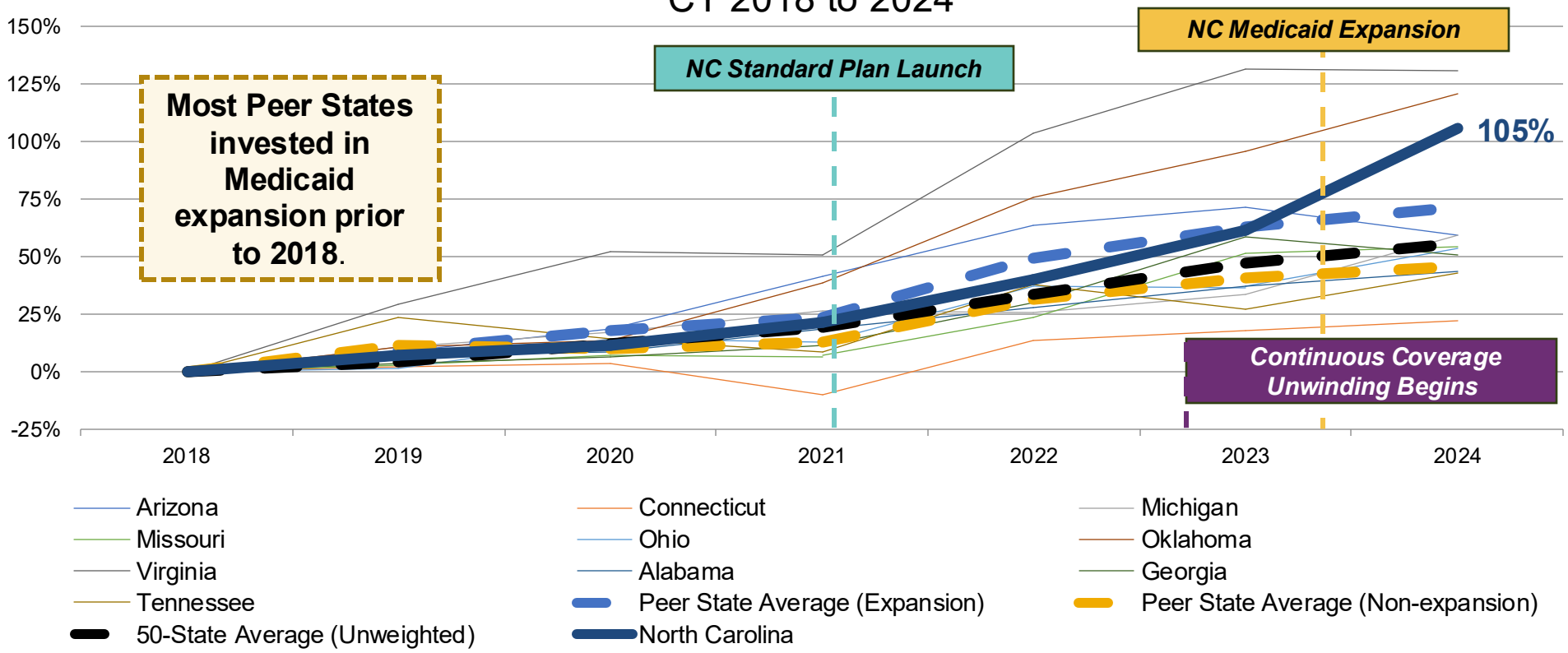
Notes: North Carolina expanded Medicaid in December 2023. 2020 data are missing from the report due to COVID-19 disruptions to survey data collection. Values include individuals who have no evidence of other coverage or only Indian Health Services coverage. Peer State averages are unweighted. CY= Calendar Year.

Source: KFF State Health Facts analysis of Census Bureau American Community Survey (ACS) data.

Total Medicaid Spending Has Increased as More People Gained Coverage

The rate of growth in total Medicaid spending in North Carolina was in line with most Peer States' rate of growth through 2023, diverging in 2024 when the state expanded Medicaid.

Growth in Total Computable Medicaid Benefit Spending Relative to CY 2018, CY 2018 to 2024



State	Spending (CY 2024)
North Carolina	$27.6B
Alabama	$8.2B
Arizona	$20.0B
Connecticut	$10.8B
Georgia	$16.4B
Michigan	$26.8B
Missouri	$16.0B
Ohio	$34.8B
Oklahoma	$10.6B
Tennessee	$13.5B
Virginia	$21.6B

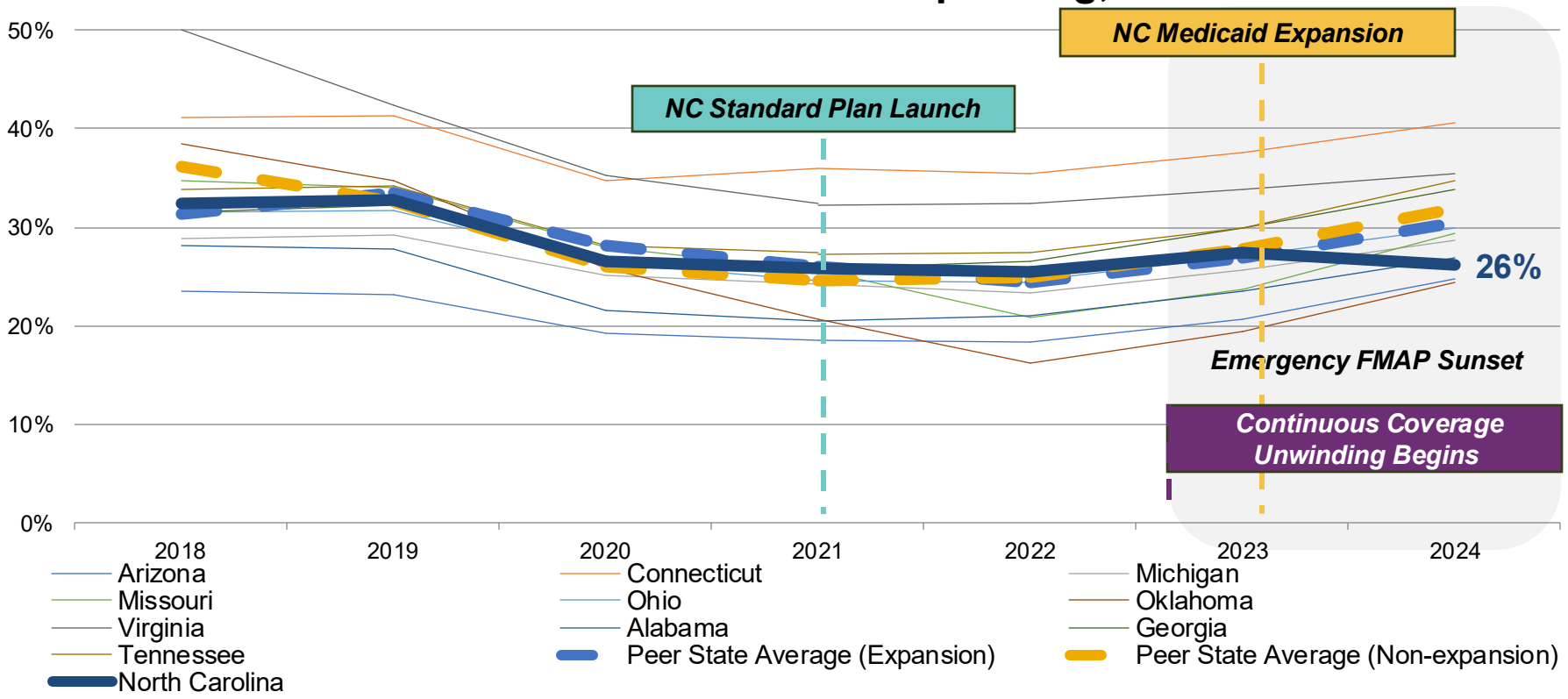
Notes: North Carolina expanded Medicaid in December 2023. Expenditures values include Medicaid and M-CHIP medical assistance payments, including federal and state shares. Spending reflects total computable spending. Peer State averages are unweighted and reflect states' expansion status as of the end of the time period. CY = Calendar Year.

Source: CMS-64 Medicaid Budget and Expenditure System (MBES) reports.

The State Share of Medicaid Spending Has Decreased

North Carolina's state share of Medicaid spending decreased from 2023 to 2024, counter to trends experienced by most Peer States.

State Share of Total Medicaid Benefit Spending, CY 2018 to 2024



Key Consideration

North Carolina's **FMAP decreased from 74% in 2023 to 65% in 2024** with the sunsetting of COVID-19 related emergency FMAPs. However, in 2024, North Carolina was able to draw down an enhanced 90% FMAP for the Medicaid expansion population, **lowering its total state share and countering trends observed across Peer States**.

(See Appendix for additional detail on changes to North Carolina's FMAP over time.)

Notes: North Carolina expanded Medicaid in December 2023. Expenditures values include Medicaid and M-CHIP medical assistance payments, including federal and state shares, and reflect expenditures associated with state-directed payments and provider tax-financed supplemental payments. Spending does not reflect administrative spending by the state. Peer State averages are unweighted. CY = Calendar Year.

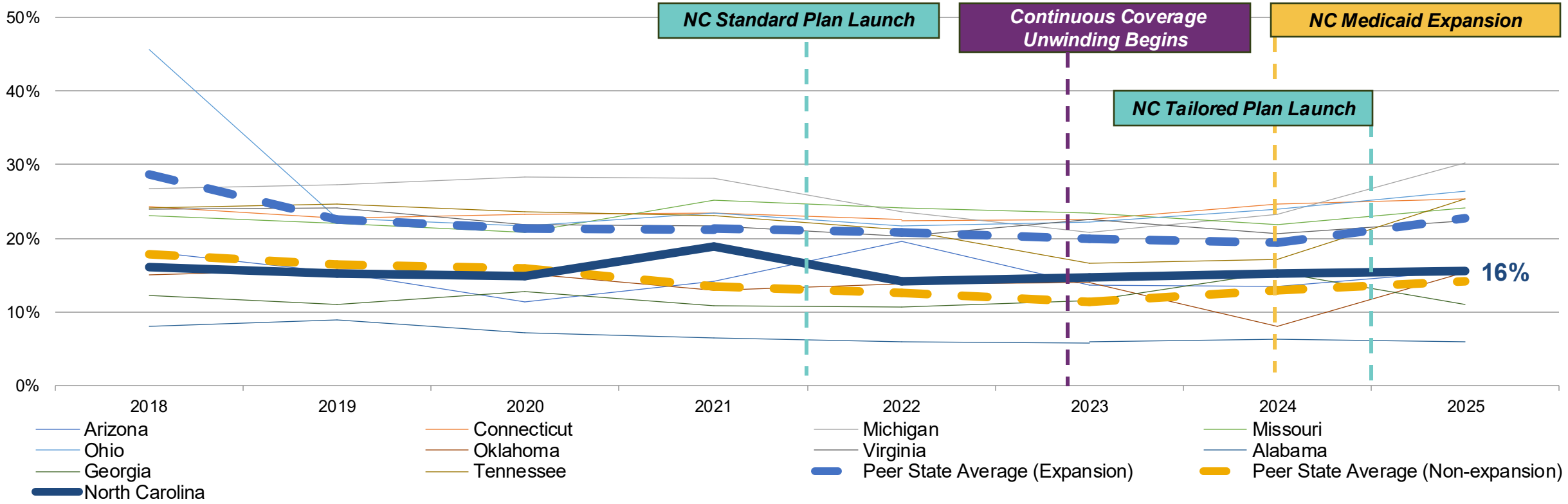
Source: CMS-64 Medicaid Budget and Expenditure System (MBES) reports; KFF State Health Facts analysis of Federal Register rules.

Medicaid as a Share of State General Fund Spending Has Been Flat

Medicaid benefit spending as a share of state general fund spending in North Carolina has remained largely flat and below that of Peer States from 2019 to 2025, despite Medicaid Expansion.

Medicaid Benefit Spending as a Share of General Fund Spending, SFY 2019 to 2025

Data reflect General Fund payments through FY26, which differ from prospective legislative budget appropriations (see notes).



Notes: North Carolina expanded Medicaid in December 2023. Medicaid General Fund expenditures and State General Fund expenditures are self-reported by states to NASBO. Data show spending flat as a percentage of total General Fund spending, though total NASBO-reported Medicaid spending grew over the period ($3.65B, FY18 to $4.9B, FY25). NASBO Medicaid spending data reflect direct state General Fund spending (see appendix). Temporary enhanced federal match rate ended on Sept. 30, 2025, resulting in increases in Medicaid budgets and appropriation requirements thereafter. Spending does not reflect administrative spending by the state or managed care plans. Peer State averages are unweighted. SFY = State Fiscal Year.

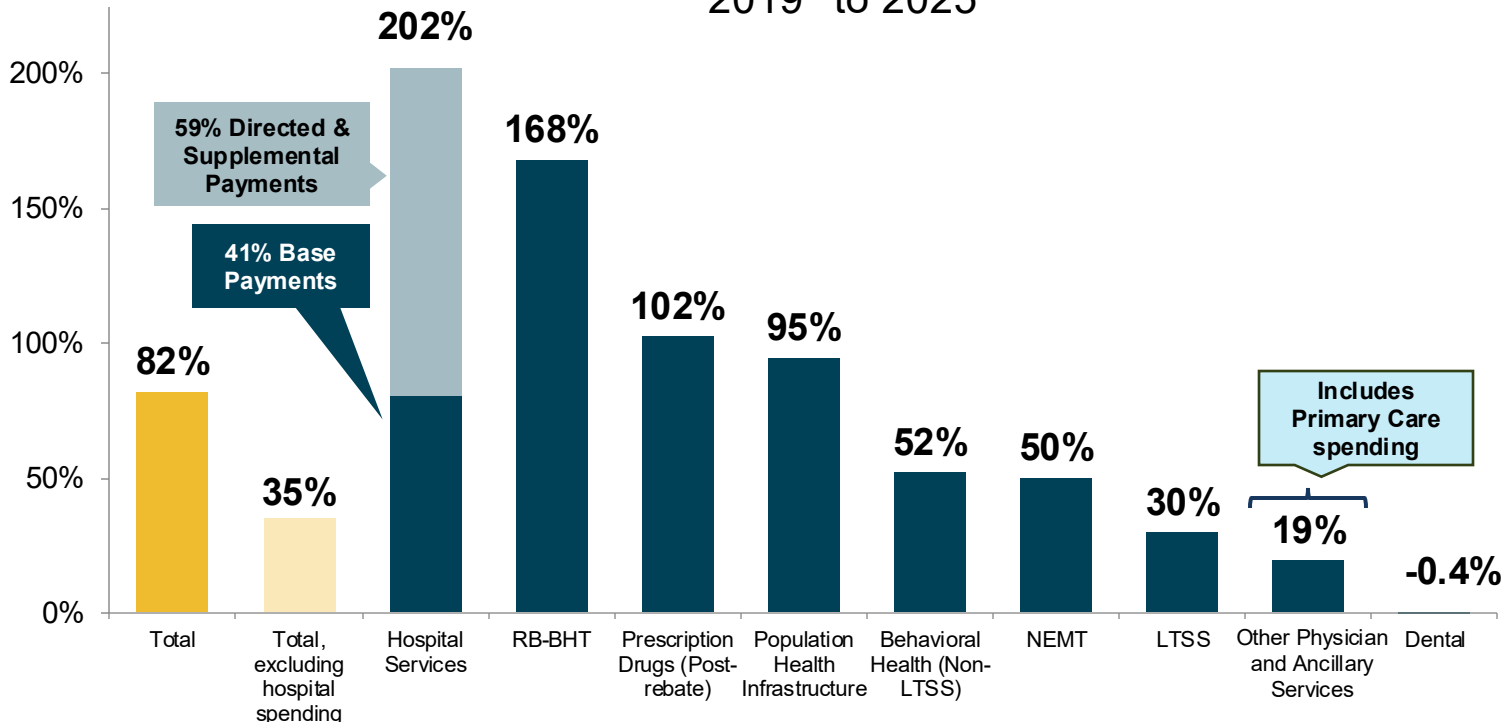
Source: National Association of State Budget Officers (NASBO) State Expenditure Report.

II.c. Focus Area Findings

Hospital Spending is the Biggest Driver of NC Medicaid Cost Growth

Variation in cost drivers and growth by service lines and populations indicate opportunities to enhance program value.

Growth in Medicaid Benefit Spending Per Enrollee by Category Relative to 2019, 2019^ to 2025



	% Change in Spending, *2019^ – 2025*	Total Spending (Millions), *2025*
TOTAL	**82%**	**$28,133M**
TOTAL, excluding hospital	**35%**	**$15,644M**
Total Hospital Services	202%	$12,488M
Base Payments	114%	$5,946M
Directed + Supplemental Payments	384%	$6,541M
Total LTSS	30%	$6,407M
Home and Community-Based Services (HCBS) LTSS	28%	$3,131M
Institutional LTSS	32%	$3,276M
Prescription Drugs (Post-rebate)	102%	$2,245M
Behavioral Health (Non-LTSS)	51%	$2,125M
RB-BHT	168%^	$539M
Other Physician and Ancillary Services (includes Primary Care)	19%	$2,902M
Pop. Health Infrastructure	95%	$742M
Non-Emergency Medical Transportation	50%	$143M
Dental	-0.4%^^	$541M

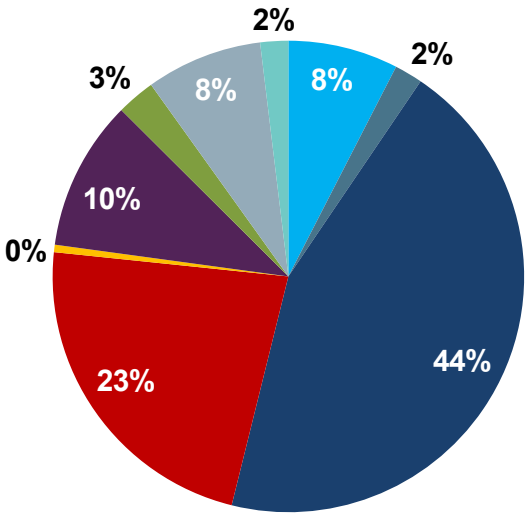
Notes: Spending captured in Universal Base Data Summary (UBDS) reports includes FFS and managed care spending. Managed care plan capitation payments, administrative spending by the state, and managed care plans are excluded from totals. Data on FFS Supplemental Payments in SFY 2025 are unavailable. Hospital directed payments include payments subject to separate payment terms as well as outpatient lab directed payments. Enrollee counts are based on MACPAC's approach for calculating full year equivalent enrollees. Pop. Health Infrastructure spending includes HOP services and coordination prior to program cancelation Years reflected in UBDS reports may reflect calendar or state fiscal years. SFY = State Fiscal Year.
^Growth in RB-BHT spending is calculated using SFY 2023 as the base year given data limitations. ^^Dental per-enrollee spending declined 0.4% from 2019 to 2025, though total dental spending increased over the same period as enrollment growth outpaced the decline in spending per enrollee.

Source: North Carolina spending by service category from Marsh UBDS Reports; Hospital FFS supplemental payments from CMS-64 MBES Reports; Hospital directed payments from analysis of CMS preprints.

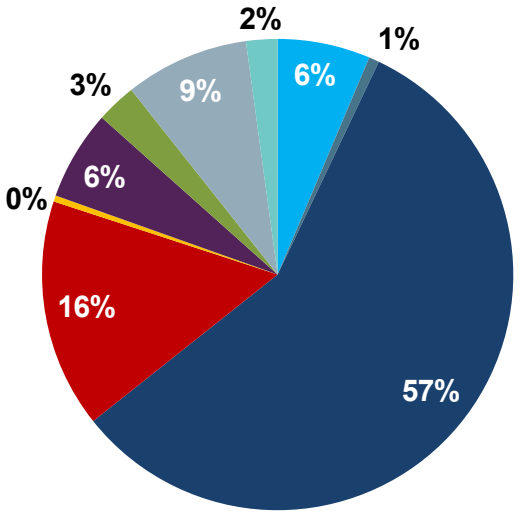
Most NC Medicaid Spending is on Hospitals, LTSS, and Prescription Drugs

Spending on hospital services accounted for a large proportion of overall Medicaid spending in 2025, with LTSS and prescription drugs accounting for the next-largest shares.

Share of Total Medicaid Benefit Spending by Category, 2025



Share of Total Medicaid Benefit Spending Growth by Category, 2019 to 2025



	% of Total Spending, *2025*	% of Total Spending Growth, *2019 – 2025*
Total Hospital	44%	57% (+13 pts)
Base Payments	21%	24% (+3 pts)
Directed + Supplemental Payments	23%	34% (+11 pts)
Total LTSS	23%	16% (-7 pts)
HCBS LTSS	11%	8% (-3 pts)
Institutional LTSS	12%	8% (-4 pts)
Prescription Drugs (Post-rebate)	8%	9% (+1 pt)
Behavioral Health (non-LTSS)	8%	6% (-2 pt)
RB-BHT	2%	2% (+0 pt)
Other Physician and Ancillary Services (includes Primary Care)	10%	6% (-4 pts)
Pop. Health Infrastructure	3%	3% (+0 pt)
NEMT	0%	0% (+0 pt)

Notes: Spending captured in Universal Base Data Summary (UBDS) reports includes FFS and managed care spending. Managed care plan capitation payments, administrative spending by the state, and managed care plans are excluded from totals. Growth in RB-BHT spending calculated using SFY 2023 as base year given data limitations. Pop. Health Infrastructure spending includes HOP services and coordination prior to program cancelation. Data on FFS Supplemental Payments in SFY 2025 are unavailable. Hospital directed payments include payments subject to separate payment terms as well as outpatient lab directed payments. Enrollee counts based on MACPAC approach for calculating full year equivalent enrollees (see appendix for details). Years reflected in UBDS reports may reflect calendar or state fiscal years. SFY = State Fiscal Year.

Source: North Carolina spending by service category from Marsh UBDS Reports; Hospital FFS supplemental payments from CMS-64 MBES Reports; Hospital directed payments from Manatt analysis of CMS preprints

II.c. Focus Area Findings

Hospital Services

Landscape Analysis Key Takeaways–Hospital Services

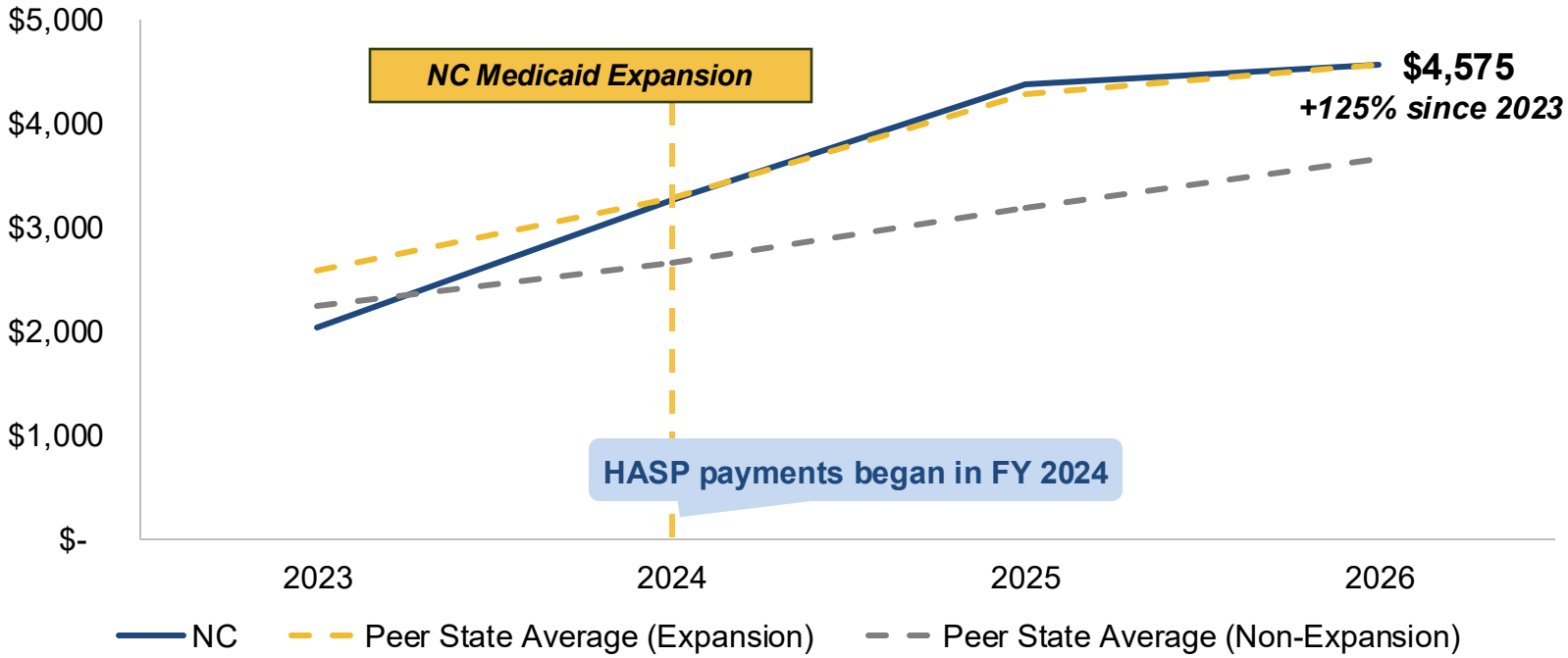
- **Hospitals are the largest cost center and cost growth driver in North Carolina Medicaid, reflecting the state's significant recent investments in hospital payments.** Since 2023, Medicaid hospital spending per enrollee increased by more than $2,000—or 125%—driven by the launch of the Healthcare Access and Stabilization Program (HASP) at no state cost.
- **North Carolina has made these investments at no state cost** while allowing the state to expand Medicaid, launch the medical debt mitigation program (MDMP), and enhance hospital reimbursement through HASP.
- **H.R. 1's Medicaid cuts are expected to reverse much of the recent Medicaid hospital spending increases over time.**
  - By 2034, hospital spending is expected to decline by ~40% v. pre-H.R. 1 expectations.
  - **As payments decline under H.R. 1, North Carolina will need to be strategic about maximizing the value of its remaining investments**—including preserving Medicaid expansion, leveraging the MDMP as a backstop for patients that lose coverage under H.R. 1, and closing quality gaps.
  - Despite impending H.R. 1 cuts, **North Carolina hospital revenues from Medicaid expansion** utilization and HASP **are expected to exceed expansion-related liabilities** (assessments funding HASP and the non-federal share of expansion, along with MDMP costs) **for at least ten years**.
- For **quality measures related to care transitions that rely on hospital quality** as well as ambulatory care, North Carolina has had mixed performance.
  - Performance on measures of follow-up after ED visits and hospitalizations for behavioral illness have been lower (worse) than national medians in recent years.
  - Rates of hospital readmission have been lower (better) than national medians in the same time frame.

Note: Hospital spending includes inpatient and outpatient hospital services, including FFS and managed care base payments (which capture facility fees for outpatient care), FFS supplemental payments, and hospital state directed payments (e.g., HASP). Hospital directed payments include payments subject to separate payment terms as well as outpatient lab directed payments.

NC Medicaid Hospital Spending Increased Substantially Since 2023

Per enrollee hospital spending has more than doubled since 2023, largely driven by the adoption of HASP at no state cost. Both per enrollee and total hospital spending remain in line with Peer Expansion States.

Total Medicaid Hospital Spending Per Enrollee, FFY 2023–2026



Hospital Spending as a % of Total Medicaid Benefit Spending, FFY 2026

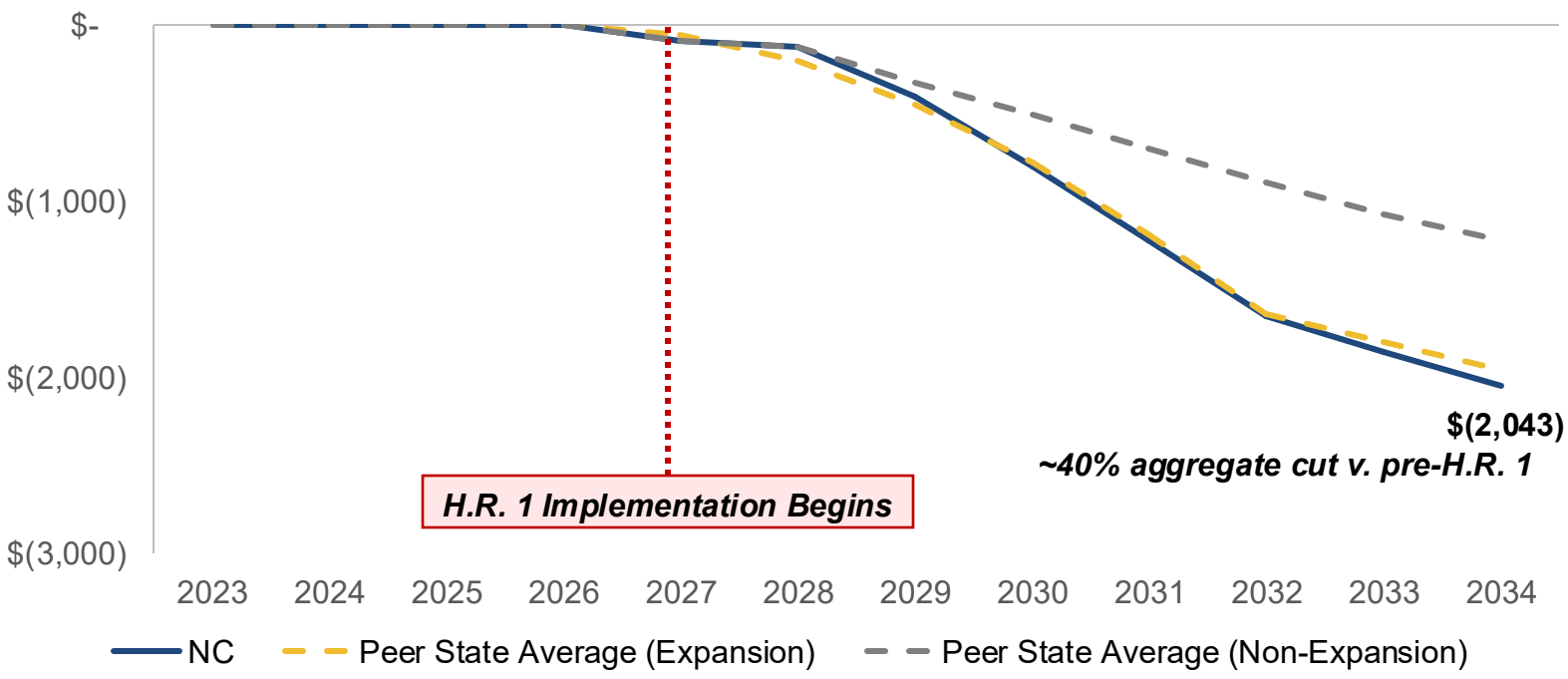
State	% of Total Medicaid Spend
Peer State Avg. (Expansion)	37%
North Carolina	**39%**
Peer State Avg. (Non-Expansion)	42%

Notes: North Carolina expanded Medicaid in December 2023. Hospital spending includes inpatient and outpatient hospital services, including FFS and managed care base payments, FFS supplemental payments, and hospital state directed payments. Hospital directed payments include payments subject to separate payment terms as well as outpatient lab directed payments. Peer State averages are unweighted. The Manatt 50-State Medicaid Financing Model estimates how key Medicaid provisions in H.R. 1—the One Big Beautiful Bill Act ("OBBBA")—would affect federal and state Medicaid spending and enrollment from FFY 2025–2034. The model projects impacts on overall Medicaid spending and hospital spending at both the state and eligibility-group levels for select Medicaid provisions.

H.R. 1 Will Reverse Most of the Spending Increase from HASP

H.R. 1's SDP and provider tax limits will reduce Medicaid hospital spending by ~40% per enrollee compared to pre-H.R. 1 expectations.

Expected Per-Enrollee Reductions in Hospital Spending Due to H.R. 1, FFY 2023–2034
Compared to Pre-H.R. 1 Baseline



Key Findings

- **North Carolina's hospital spending is expected to decrease by >$2,000 per enrollee by 2034,** in line with Peer Expansion States.
- **North Carolina's cuts will be more significant than in Peer Non-expansion States** as H.R. 1 only reduces the tax rate for expansion states.
- Cuts are likely to have a **significant impact on hospitals,** though North Carolina hospital revenues from Medicaid expansion utilization and HASP are expected to exceed expansion-related liabilities for at least ten years.

Notes: Hospital spending includes inpatient and outpatient hospital services, including FFS and managed care base payments, FFS supplemental payments, and hospital state directed payments. Hospital directed payments include payments subject to separate payment terms as well as outpatient lab directed payments. Peer State averages are unweighted. Hospital spending as a share of total Medicaid spending may differ slightly from other analyses due to source differences. This slide uses Manatt's Medicaid financing model, while other analyses use Marsh UBDS data. The Manatt 50-State Medicaid Financing Model estimates how key Medicaid provisions in H.R. 1—the One Big Beautiful Bill Act ("OBBBA")—would affect federal and state Medicaid spending and enrollment from FFY 2025–2034. The model projects impacts on overall Medicaid spending and hospital spending at both the state and eligibility-group levels for select Medicaid provisions.

II.c. Focus Area Findings

Prescription Drugs

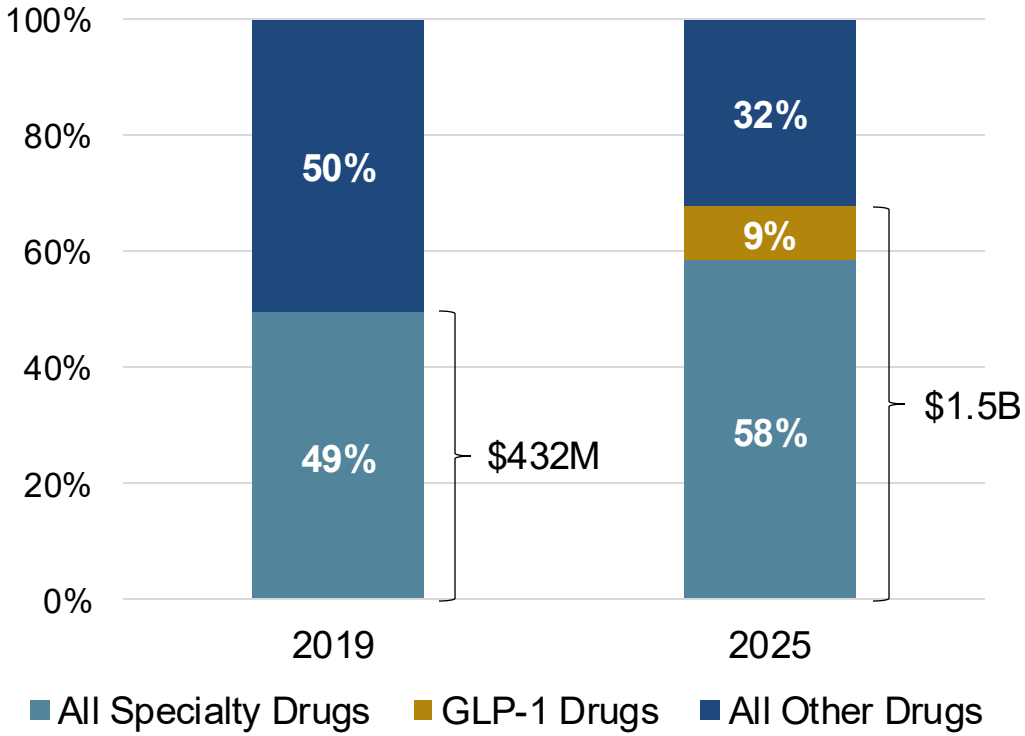
Landscape Analysis Key Takeaways–Prescription Drugs

- **Prescription drugs are a significant cost center in North Carolina and in recent years have become a notable cost growth driver**.
- **Pre-rebate drug spending per enrollee grew on par with most Peer States** from 2018 to 2024 before increasing rapidly in 2025.
- **Growth in 2025 may have been driven by North Carolina's coverage of GLP-1 drugs for weight management** beginning in August 2024.
  - GLP-1 drug spending per enrollee increased significantly from 2024 to 2025.
- **Recent growth in post-rebate spending has been driven by specialty drugs, including cell and gene therapies to treat sickle cell disease and cancers such as leukemia.**
  - Post-rebate spending per enrollee on specialty drugs increased nearly 139% from 2019 to 2025 while per enrollee spending on other drugs only increased 66%.
  - In 2025, specialty drugs accounted for fewer than 2% of all pharmacy claims but nearly 60% of total post-rebate drug spending.
- **North Carolina's prescription drug rebates have not kept pace with growth in gross drug spending.**
  - Rebates as a share of gross drug spending decreased from 61.1% in 2022 to 54.5% in 2025, slightly above the national average of 53.5%.

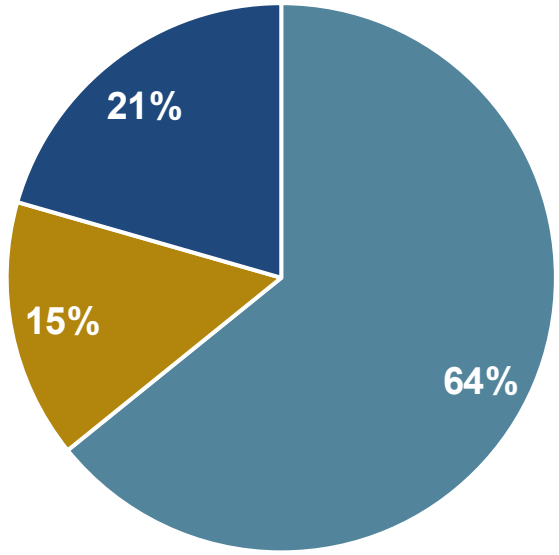
GLP-1s and Specialty Drugs Drove NC Medicaid Pharmacy Spending Growth

Post-rebate spending on GLP-1s and specialty drugs more than tripled between 2019 and 2025. These drugs accounted for nearly 80% of the growth in North Carolina Medicaid's post-rebate drug spending over the period.

Share of Post Rebate Pharmacy Spending by Drug Type, CY 2019 to 2025



Share of Post Rebate Pharmacy Spending Growth by Drug Type, CY 2019 to 2025

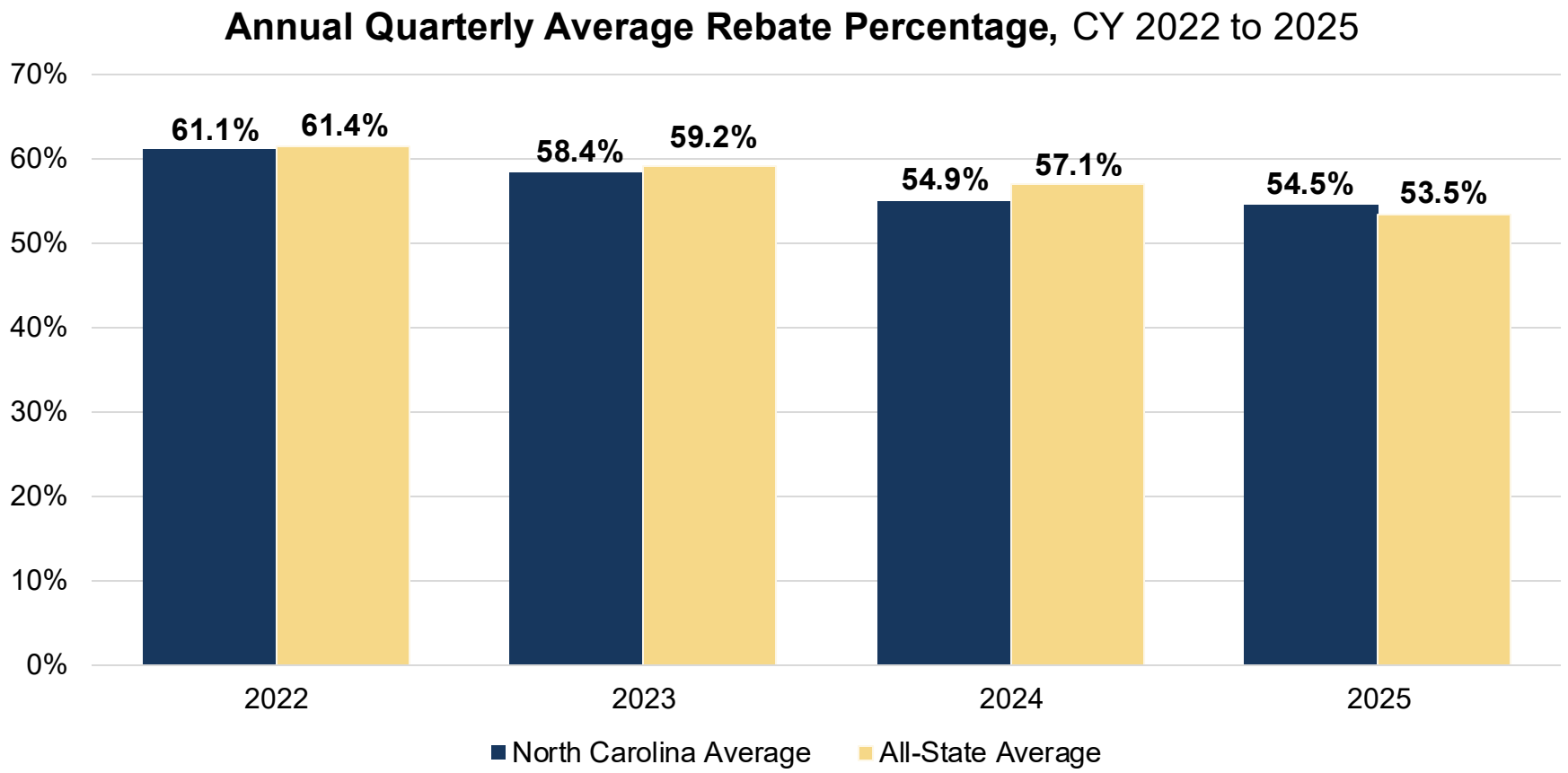


Notes: GLP-1 drugs are classified as non-specialty drugs for the purposes of this analysis. Growth in specialty drug spending may reflect drugs reclassified from traditional to specialty in 2021–2022, as well as increased utilization of drugs that entered the market during this period.

Source: Analysis of post-rebate spending and claims data provided by Prime Therapeutics.

NC Pharmacy Rebates Track the National Average as a Share of Spending

North Carolina's prescription drug rebates have not kept pace with growth in gross drug spending, consistent with national trends.



Note: Rebate percentages reflect the average of four quarterly rebate percentages for each calendar year, as calculated by Prime Therapeutics.

Source: Prime Therapeutics, "North Carolina Rebate Change," September 2026.

II.c. Focus Area Findings

LTSS

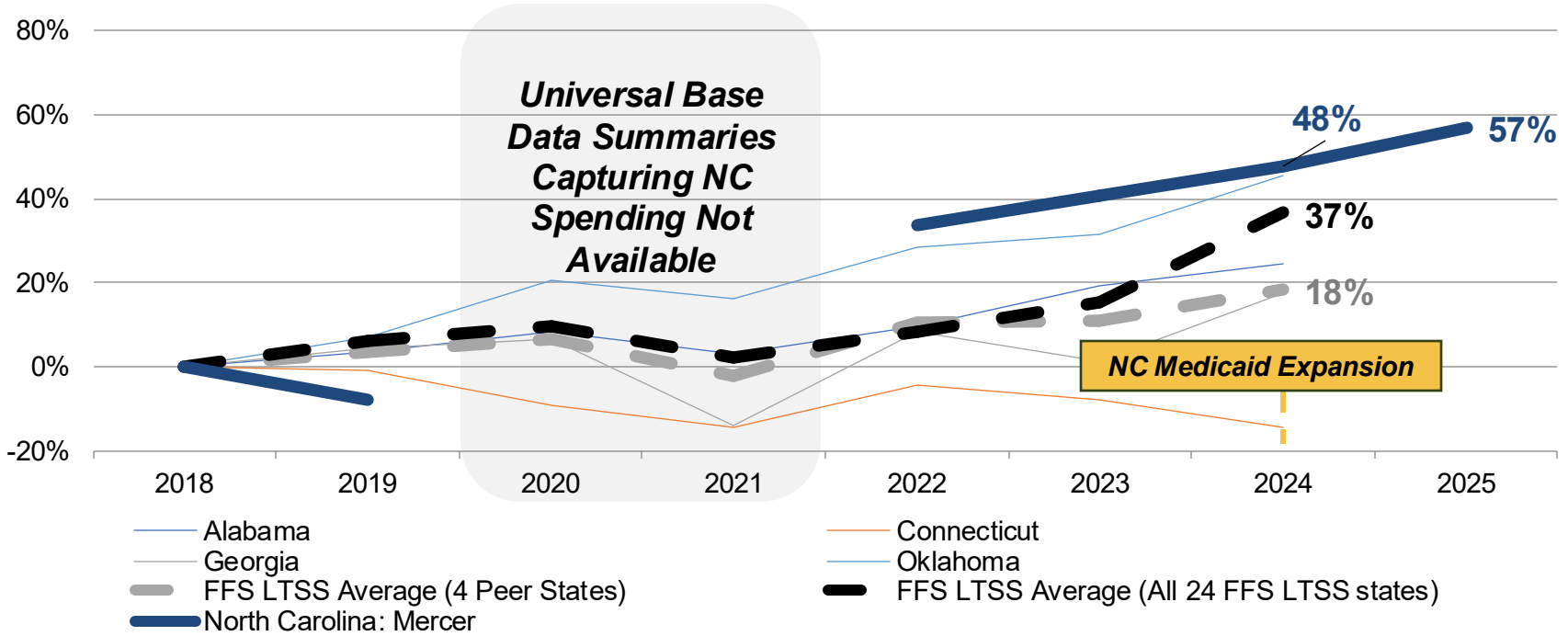
Landscape Analysis Key Takeaways – LTSS

- **LTSS is a major cost center in North Carolina Medicaid (as it is in all states) but not a major cost growth driver.**
  - Growth in LTSS spending per aged or disabled enrollee in North Carolina lagged the growth across all FFS LTSS states nationwide (45% in North Carolina v. 69% across all FFS LTSS states) between 2018 and 2024.
- **North Carolina's institutional LTSS spending per enrollee grew faster than other states** (48% growth in North Carolina v. 37% across all FFS LTSS states) and continues to rise, with growth largely driven by an 89% increase in average per diem Skilled Nursing Facility (SNF) rates from 2019 to 2026. The rate increase was initially federally mandated in 2020 in response to COVID-19 and was made permanent by the North Carolina General Assembly in 2023.
- **North Carolina's HCBS LTSS spending growth per enrollee trailed growth in other states** (42% in North Carolina v. 111% across all FFS LTSS states).
- In 2024, **HCBS comprised 48% of total LTSS spending in North Carolina, below the average of 60% across all FFS LTSS states**, potentially reflecting access constraints due to waitlists for the Innovations and CAP/DA waivers and unused CAP/C waiver capacity.
- **North Carolina has made steady progress rebalancing from institutional to community-based services** with the proportion of HCBS users increasing from 75% in 2019 to 83% in 2023, outpacing growth in most Peer States, though still below the national average of 87%.
- **North Carolina ranks 41st nationally on LTSS system performance.** North Carolina ranked 41st in AARP's 2023 scorecard. It ranks higher on community integration (19th), middling on safety and quality (35th), and lower on affordability and access (46th) and caregiver support (49th).

NC Institutional LTSS Spending Has Grown Faster Than Other States

Between 2018 and 2024, North Carolina's institutional LTSS spending per aged or disabled enrollee grew at a faster pace relative to FFS LTSS states nationwide.

Growth in Institutional LTSS Spending Per Aged or Disabled Enrollee Relative to 2018, 2018 to 2025



State or Group	Institutional LTSS Spending Growth Per Enrollee, 2018 to 2024
North Carolina	**48%**
Oklahoma	46%
FFS LTSS Average (All 24 FFS LTSS states)	37%
Alabama	25%
FFS LTSS Average (4 Peer States)	18%
Georgia	18%
Connecticut	-14%

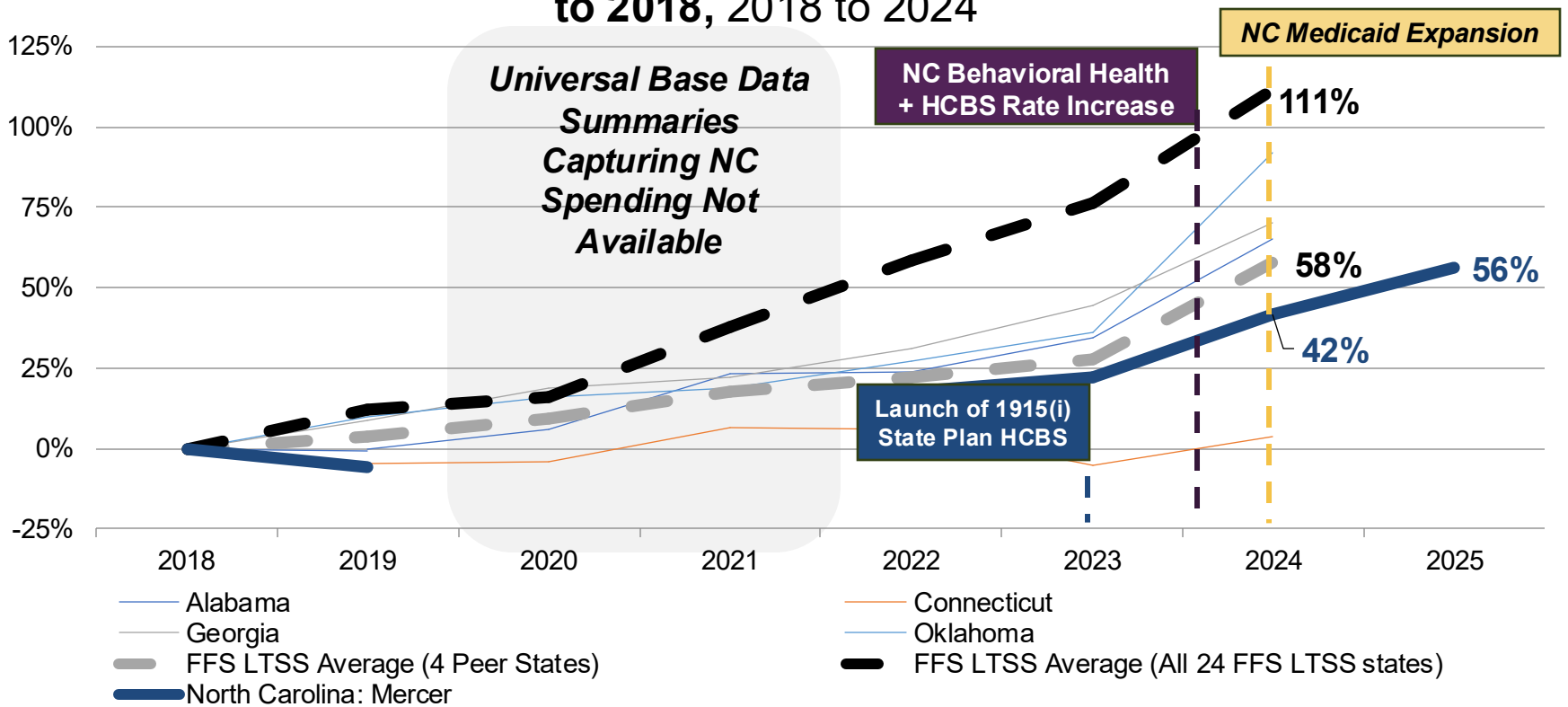
Notes: FFS = Fee-For-Service; LTSS = Long-Term Services and Supports. North Carolina expanded Medicaid in December 2023. Institutional LTSS includes hospice, ICF/IID, and nursing facility services. Years reflected in UBDS data may reflect calendar or state fiscal years. See Appendix for additional details on UBDS data. North Carolina spending includes both FFS and managed care spending. Analysis restricted to Peer States with FFS LTSS programs due to lack of publicly available data disaggregating managed care spending by service category. Peer State averages are unweighted. The FFS LTSS State Average includes Alabama, Alaska, Connecticut, Georgia, Kentucky, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Vermont, Washington, West Virginia, and Wyoming.

Source: MACPAC MACStats Exhibit 15 and Manatt analysis of T-MSIS Analytic Files. North Carolina LTSS spending from Marsh UBDS Reports; Peer state LTSS spending from CMS-64 MBES Reports

NC Community LTSS Spending Has Grown Slower Than in Other States

North Carolina Medicaid's HCBS spending per aged or disabled enrollee has grown at less than half the rate of FFS LTSS states nationwide.

Growth in HCBS LTSS Spending Per Aged or Disabled Enrollee Relative to 2018, 2018 to 2024



State or Group	HCBS LTSS Spending Growth Per Enrollee, 2018 to 2024
North Carolina	**42%**
FFS LTSS Average (All 24 FFS LTSS states)	111%
Oklahoma	92%
Georgia	70%
Alabama	65%
FFS LTSS Average (4 Peer States)	58%
Connecticut	4%

Notes: FFS = Fee-For-Service; LTSS = Long-Term Services and Supports. North Carolina expanded Medicaid in December 2023. Home and community-based services (HCBS) LTSS includes Program of All-Inclusive Care for the Elderly (PACE) and sections 1905(a), 1915(c), 1915(i), 1915(j), and 1915(k) waiver programs and benefits, including personal care services, home health services, rehabilitative services, case management services, and private duty nursing services. Years reflected in UBDS data may reflect calendar or state fiscal years. See Appendix for additional details on UBDS data. North Carolina spending includes both FFS and managed care spending. Analysis restricted to Peer States with FFS LTSS programs due to lack of publicly available data disaggregating managed care spending by service category. Peer State averages are unweighted. The FFS LTSS State Average includes Alabama, Alaska, Connecticut, Georgia, Kentucky, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Vermont, Washington, West Virginia, and Wyoming.

Source: MACPAC MACStats Exhibit 15 and analysis of T-MSIS Analytic Files. North Carolina LTSS spending from Marsh UBDS Reports; Peer state LTSS spending from CMS-64 MBES Reports

NC Trailed Peer Expansion States on LTSS Performance in 2023

North Carolina ranked 41st in AARP's 2023 LTSS scorecard but has since invested in improving access for eligible populations through system improvements, expanded access to HCBS services, and rate increases to support the HCBS workforce.

North Carolina LTSS Performance Relative to Peer States, CY 2023

State		Overall	Affordability and Access	Choice of Setting and Provider	Safety and Quality	Support for Family Caregivers	Community Integration
North Carolina		**41**	**46**	**25**	**35**	**49**	**19**
Peer State Average (Expansion)		30.0	21.7	28.9	33.6	26.3	32
Expansion	Arizona	22	29	42	22	11	20
	Connecticut	13	8	22	19	9	22
	Michigan	31	27	12	33	28	42
	Missouri	38	18	39	47	26	36
	Ohio	32	9	29	38	41	26
	Oklahoma	46	51	43	39	32	46
	Virginia	28	10	15	37	37	32
Peer State Average (Non-expansion)		45.3	35.7	41	44.3	40.7	44
Non-expansion	Alabama	50	38	51	41	48	49
	Georgia	39	26	41	43	23	38
	Tennessee	47	43	31	49	51	45

Notes: LTSS = Long-Term Services and Supports; CY = Calendar Year. Every three years, AARP produces performance indicators along five dimensions of LTSS performance. Indicators may change over years, so performance between years may not be exactly comparable. Smaller numbers indicate better performance. The 2020 version of the Scorecard labeled the "Safety and Quality" domain as "Quality of Life and Quality of Care" and the "Community Integration" domain as "Effective Transitions." Peer State averages are unweighted. Note: this time period does not reflect NC Medicaid expansion or the launch of the 1915(i) benefit.

Source: AARP LTSS 2023 State Scorecard Report.

II.c. Focus Area Findings

Primary Care and Population Health

Landscape Analysis Key Takeaways – Primary Care and Population Health

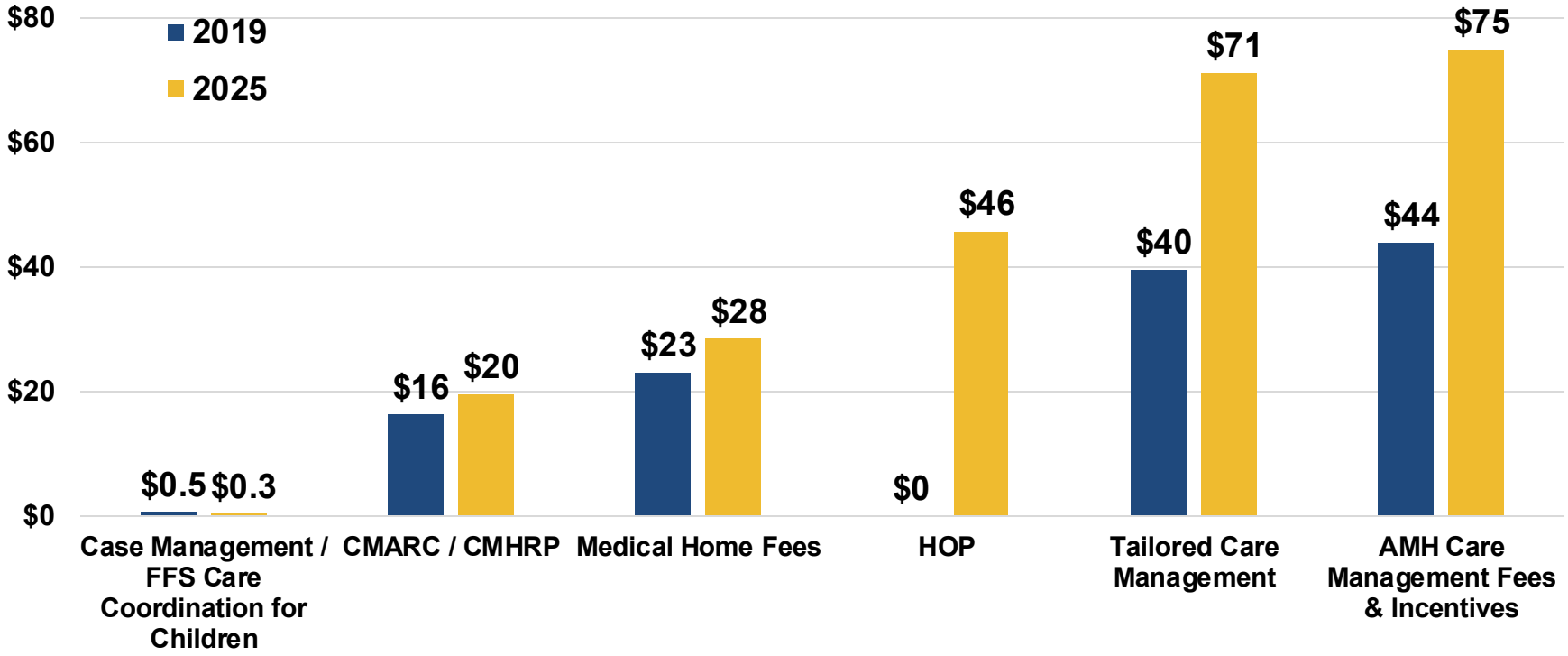
- **North Carolina is under-investing in primary care.** Primary care spending growth is not keeping pace with total benefit spending growth, and primary care was only 2.9% of benefit spending in SFY 2025.
  - Despite this, **primary care provider participation appears stable**, and AMH participation has increased.
  - **Access to ambulatory/preventive care**, while increasing, **remains more than 10 percentage points below the national average**.
  - **Chronic disease diagnosis rates are rising** across North Carolina Medicaid populations.
- **North Carolina ranks poorly on maternal and infant health outcomes:** 35th for maternal mortality and 41st for infant mortality.
- **While population health programs are not a major cost center, they are a notable cost growth driver.** Per enrollee spending on population health programs increased 95% from 2019 to 2025 as the state made **intentional investments** (including **HOP**, which **reduced health care costs by an average of $164 per month**).

Notes: AMHs = Advanced Medical Home; HOP = Healthy Opportunities Pilots. Primary care spending described on this slide is inclusive of some maternity care spending, consistent with the NC Primary Care Payment Task Force definition of primary care.

NC Made Population Health Investments in Recent Years

North Carolina has made several targeted investments in population health with the goal of keeping people healthy and preventing the need for high-cost services.

North Carolina Population Health Spending Per Enrollee, CY 2019 to 2025



Key Findings

- Between 2019 and 2025, North Carolina invested in three significant population health programs: AMH Tier 3, Tailored Care Management, and the Healthy Opportunities Pilot (HOP).
- **HOP has shown potential for net savings over time**, reducing health care costs by an average of $164 per month.
- **Tailored Care Management** has reached almost half of the highest-cost eligible individuals (a key target population), a higher rate than among eligible individuals with lower costs.

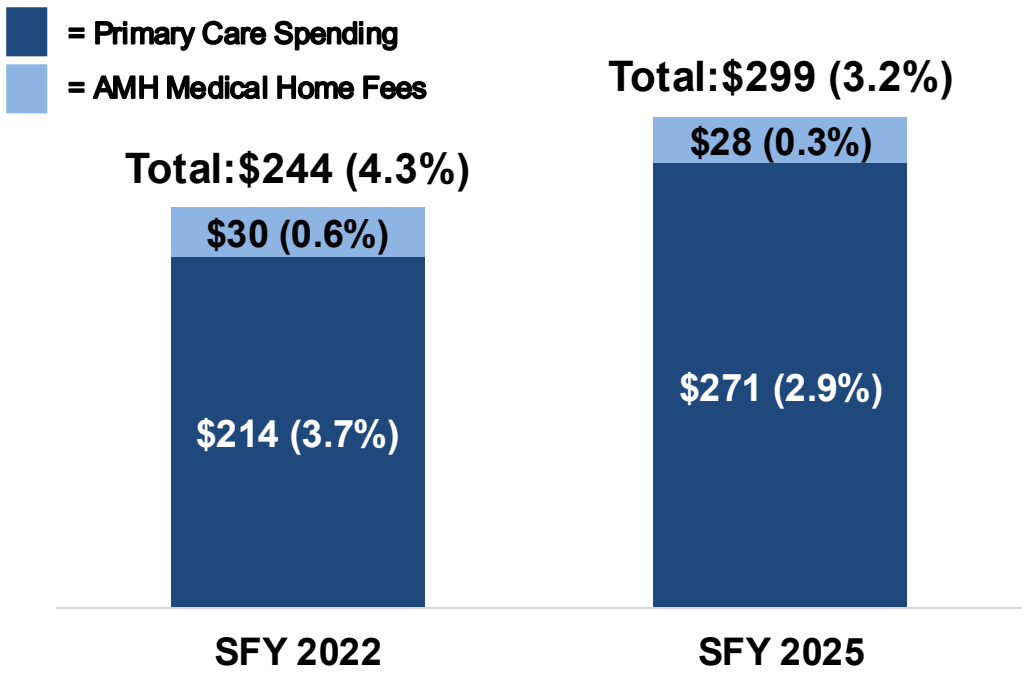
Notes: CMHRP = Care Management for High-Risk Pregnancies; CMARC = Care Management of At-Risk Children; TCM = Tailored Care Management. The AMH care management fee investment in 2025 includes PCMH payments in 2025 and is compared to PCMH payments in 2018. TCM investment in 2025 is compared to 2018 payments to LME-MCOs for care coordination; LME-MCO payments only addressed behavioral health needs, however, so this is likely an underestimate of the total amount of population health spending for populations previously served by LME-MCOs. Per enrollee per year calculated taking the total divided by the total number of Medicaid enrollees each year. Healthy Opportunities Pilots (HOP) was not available statewide like other programs. For consistency in per enrollee calculations across all Pop. Health Infrastructure areas, the HOP calculation used total number of Medicaid enrollees in North Carolina, not enrollment for HOP regions.

Source: Universal Base Data Summaries (Marsh); Administrative and LME/MCO Care Coordination Expense Summary (Marsh); North Carolina Enrollment Data (Marsh).

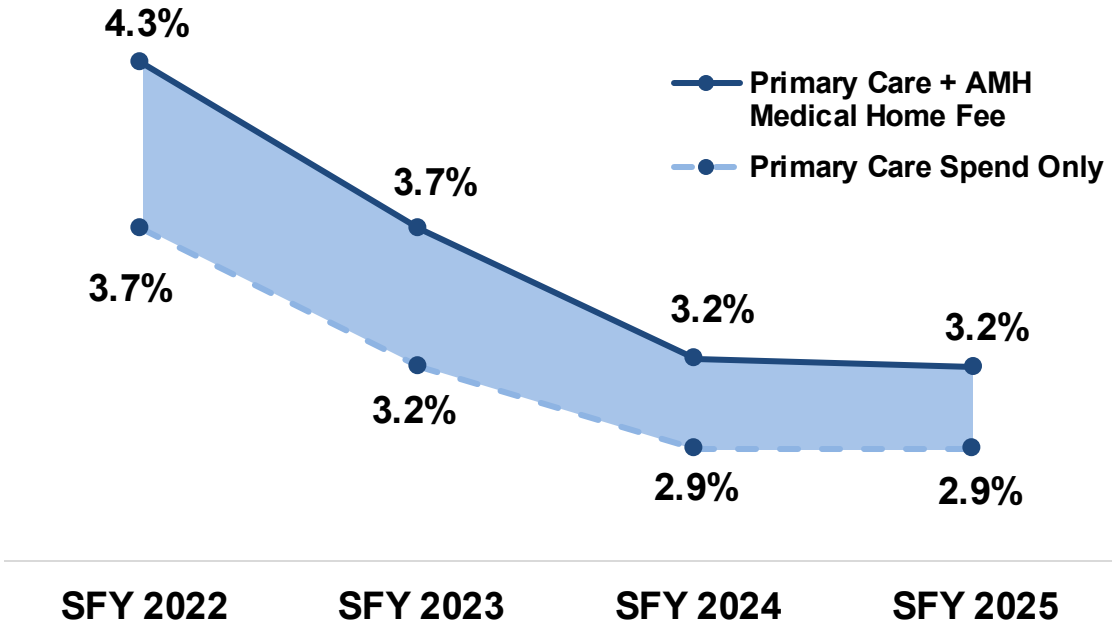
Primary Care Spending Has Declined as Percent of Total Spending

While per enrollee primary care spending increased, primary care spending declined as a percent of total spending. Primary care was only 2.9% of spending in SFY 2025 (compared to ~5% nationally). Additional North Carolina Medicaid investments in primary care help reduce that gap but do not close it entirely.

Primary Care Spending per Enrollee^ Increased (% of Total Spend), SFY 2022–2025



Primary Care Spend as % of Total Benefit Spend Declined, SFY 2022–2025

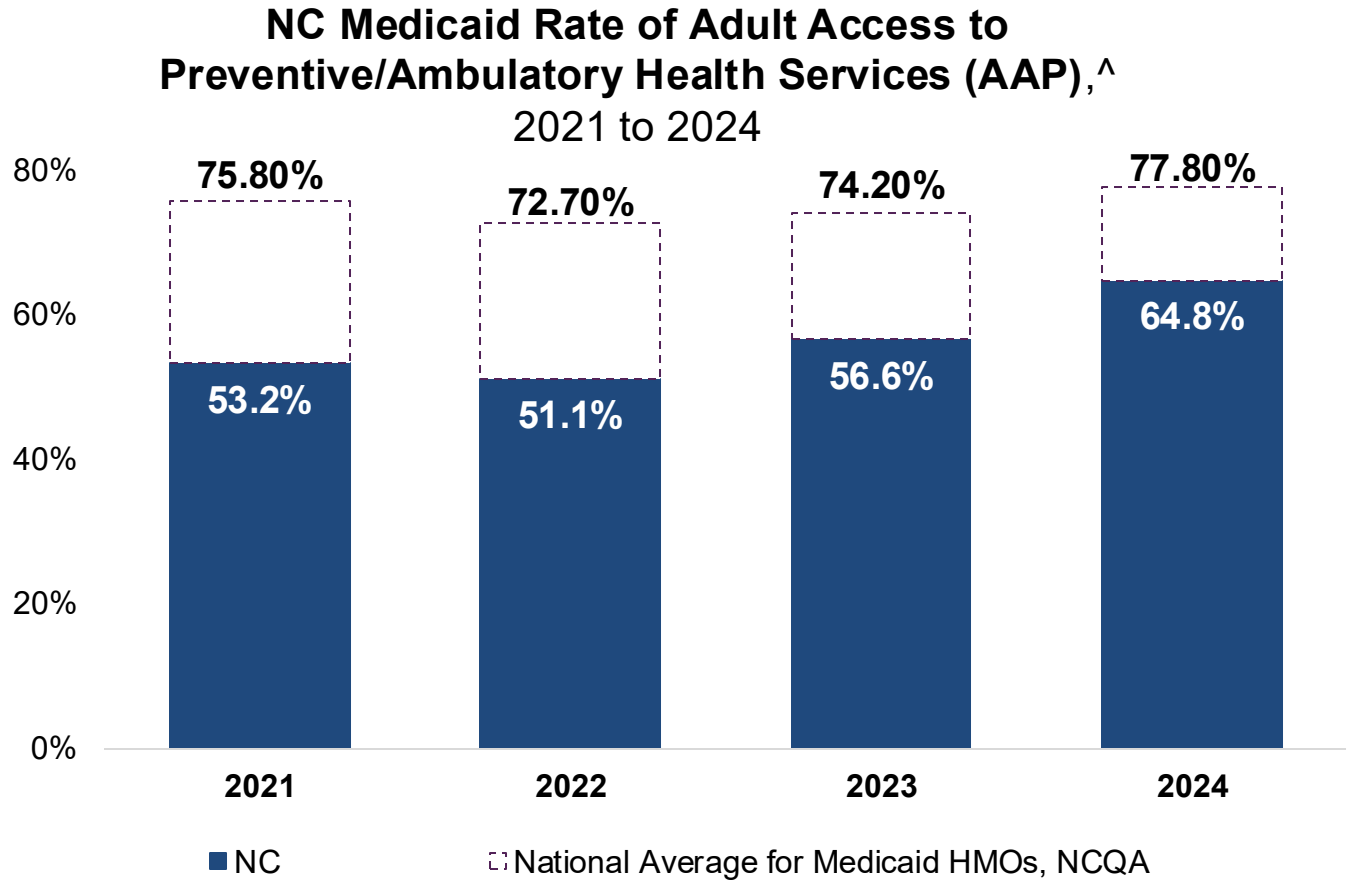


Notes: ^ Due to reporting issues in prior years, AMH medical home spending in FY 2022 may also include some spending on AMH care management fees. Benefit spending per enrollee overall for NC Medicaid was $9,223 in SFY 2025. The North Carolina Primary Care Payment Reform Task Force definition used in this analysis is not directly comparable to some national definitions, including Milbank Memorial Fund's narrow definition underlying the ~5% cited in the header.

Source: Milbank Memorial Fund, 2026 Primary Care Scorecard Data Dashboard.

Access to Preventive/Ambulatory Care Remains Below Average

Access to adult preventive/ambulatory services has been improving in North Carolina but remains below the national average.



Key Findings

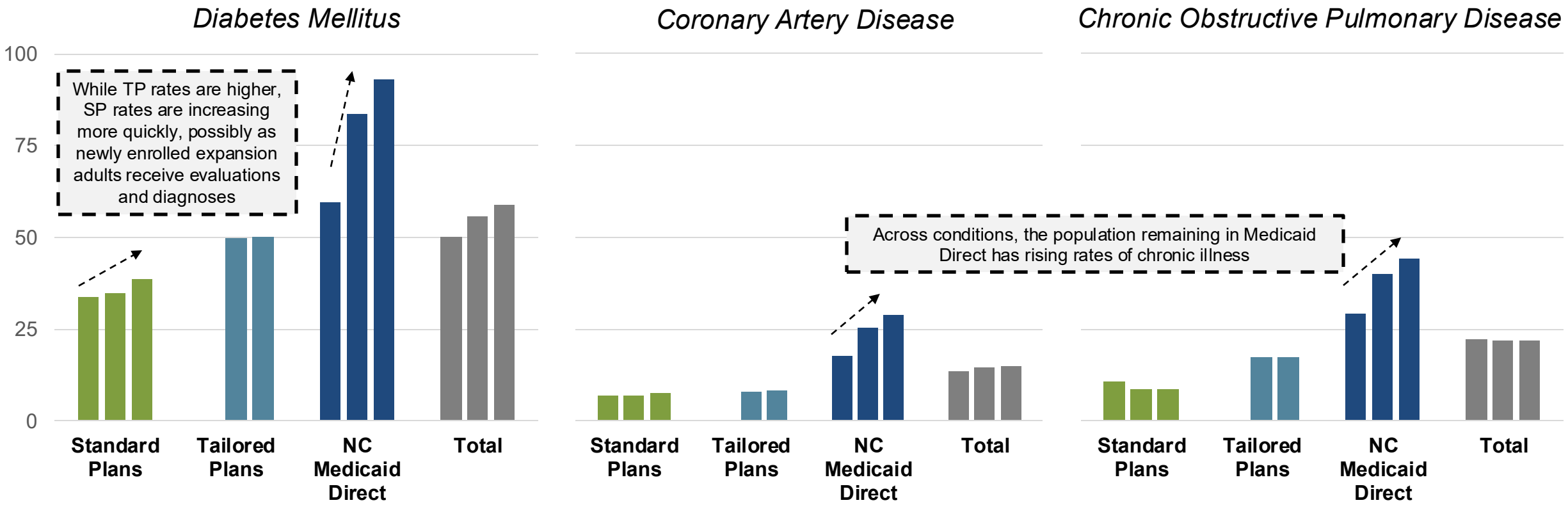
- Between 2021 and 2024, adult access to preventive/ambulatory health services increased from 53.2% to 64.8%.
- North Carolina's adult access to preventive/ ambulatory health services remained below the national average of 77.8% in 2024.

Notes: Average across Standard Plans only. Plan reported for annual risk corridor calculations. SFY = State Fiscal Year. ^The percentage of members ages 20 and older who had one or more ambulatory or preventive care visits (e.g., annual physical exams, evaluation and management visits).
Source: NC Medicaid Quality Fact Sheets: Access to Care; NCQA HEDIS Measure Library & Historical Data

Rates of Chronic Disease in NC Medicaid Are Rising

Chronic disease diagnosis rates are generally rising across North Carolina Medicaid populations, especially for diabetes, and with higher rates within Tailored Plan and Medicaid Direct.

NC Medicaid Chronic Disease Diagnosis Rates per 1,000 Medicaid Beneficiaries by Delivery System, 2023 – 2025



Notes: North Carolina expanded Medicaid in December 2023. Most expansion adults enrolled in Standard Plans, so 2024 and 2025 Standard Plan rates reflect a changing population. Newly enrolled adults may have had conditions that were not previously diagnosed. Individuals remaining in NC Medicaid Direct were more likely to be significantly older and dually eligible for Medicare than those who transitioned to Standard or Tailored Plans. Broader increases may reflect a sicker population, better identification of previously undiagnosed conditions, or changes in documentation patterns.

Source: NCDHHS Quality, Population Health, and Evaluation team data.

II.c. Focus Area Findings

Behavioral Health

Landscape Analysis Key Takeaways – Behavioral Health

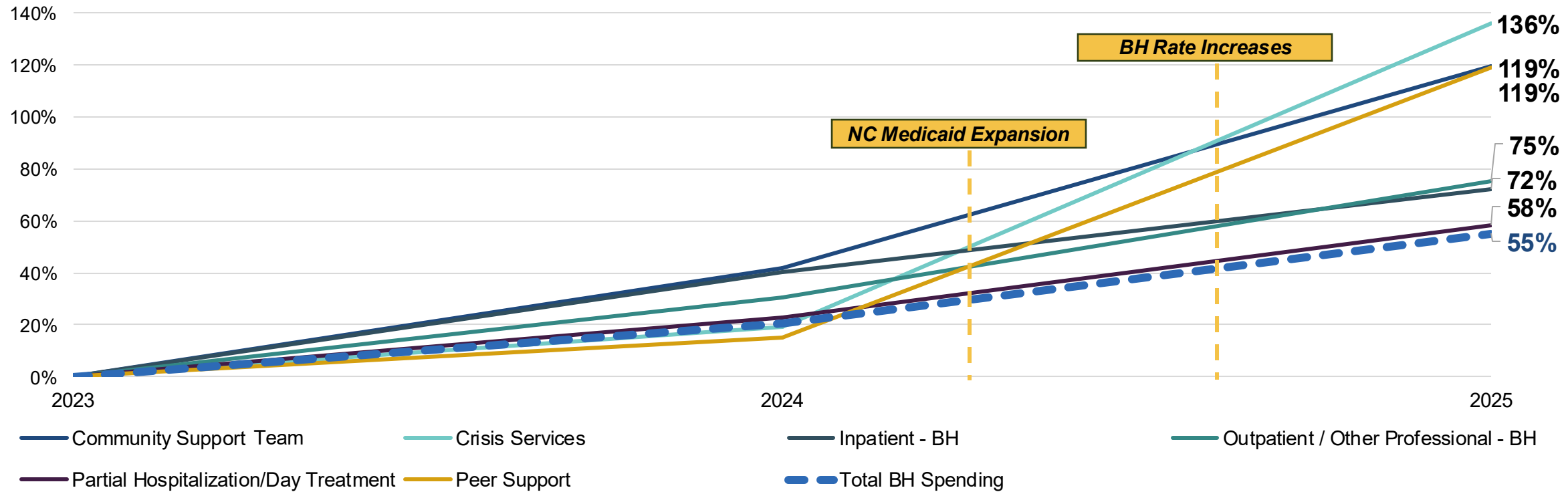
- **Behavioral health services are a significant cost center in North Carolina but not a major cost growth driver.**
  - **From 2019 to 2025, North Carolina's behavioral health spending per enrollee increased 52%** as the state transitioned to Tailored Plans (7/2024) and implemented Tailored Care Management (12/2022) and the 1915(i) benefit (7/2023). A legislatively directed rate increase during the lookback period (1/2024) accounts for a portion of the increase.
- **The effects of this transition are not yet fully evident in outcomes data.** North Carolina performed around or below the national median on 12 of 13 Medicaid core set measures related to behavioral health in 2024 and still has higher rates of unmet need for mental health treatment.
  - However, North Carolina has **begun to see some improvements in its SUD outcomes**, including a 34% decline in overdose deaths from 2023 to 2024[1] and consecutive years of decreasing emergency department visits and hospitalizations for opioid overdoses.
- Spending on **community support team (CST) and peer support** services grew more rapidly than spending on other behavioral health services over this period as did spending on **crisis services.** This growth in peer support and crisis services was the result of intentional investments in the crisis system. Some intensive services, such as Psychiatric Residential Treatment Facility (**PRTF)**, have higher baseline utilization than may be clinically indicated, with poor outcomes.
- Medicaid enrollees with SMI and/or SUD in North Carolina (23% of all enrollees) account for a **disproportionate share of spending associated with inpatient hospitalizations (46%) and ED visits (47%) for physical health**, totaling $2.15B in SFY 2025**.** These figures are in line with national data.

Source: Office of the Governor of North Carolina, "Governor Stein Highlights Drop in Overdose Deaths, Commitment to Prevent and Treating Opioid Addiction," press release, May 18, 2026.

NC Invested in Crisis, Peer Support, and Community Support Team Services

The state made deliberate investments in crisis services, community support team, and peer support services, resulting in per enrollee spending increases.

Growth in Per-Enrollee Spending in High-Growth Behavioral Health Services Relative to 2023, SFY 2023 to 2025



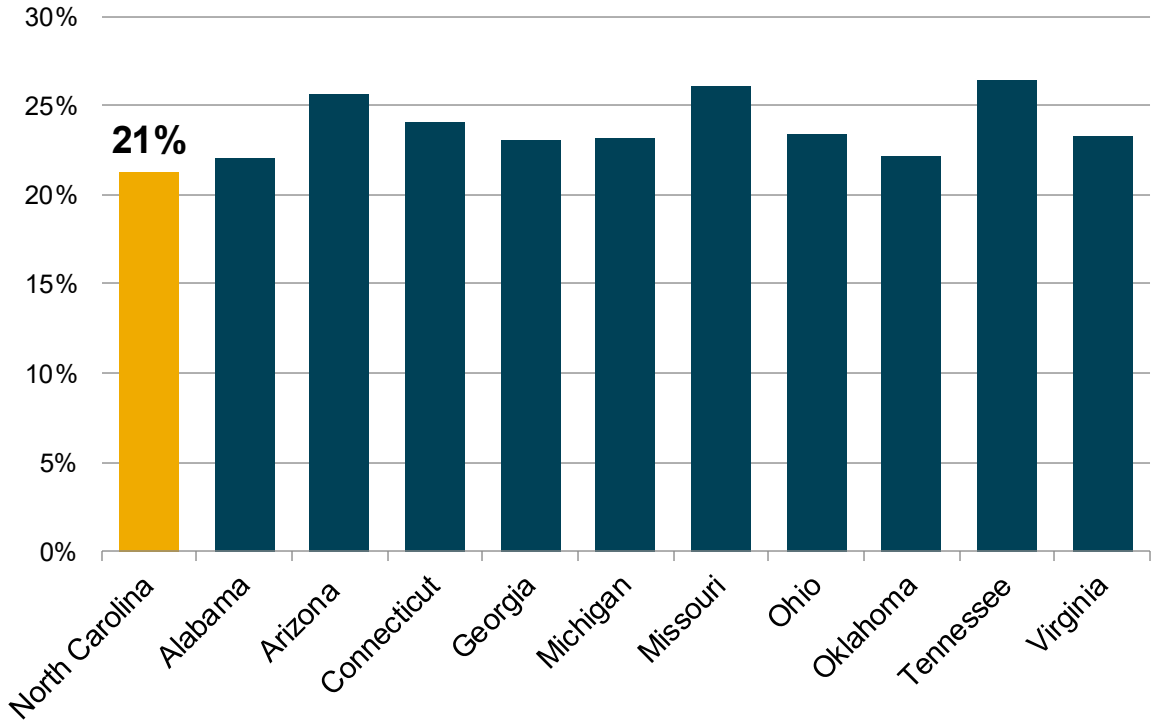
Notes: Analysis begins in SFY 2023 because services were previously grouped into broader categories in Marsh UBDS reports. Services with spending growth below the overall behavioral health spending growth rate are not shown, including Emergency Room Behavioral Health, Psychiatric Residential, PRTF, MST, IIHS, ACT, High-Fidelity Wraparound, and Behavioral Health Long-Term Residential.

Source: Analysis of Marsh UBDS reports. NCDHHS, DMHDDSUS | CBH Length of Stay and Incident Dashboards | April 28th, 2025; Analysis of Marsh-provided data, "SFY 2021-2025 PRTFs & Level 4 Therapeutic Homes Utilization of Summary."

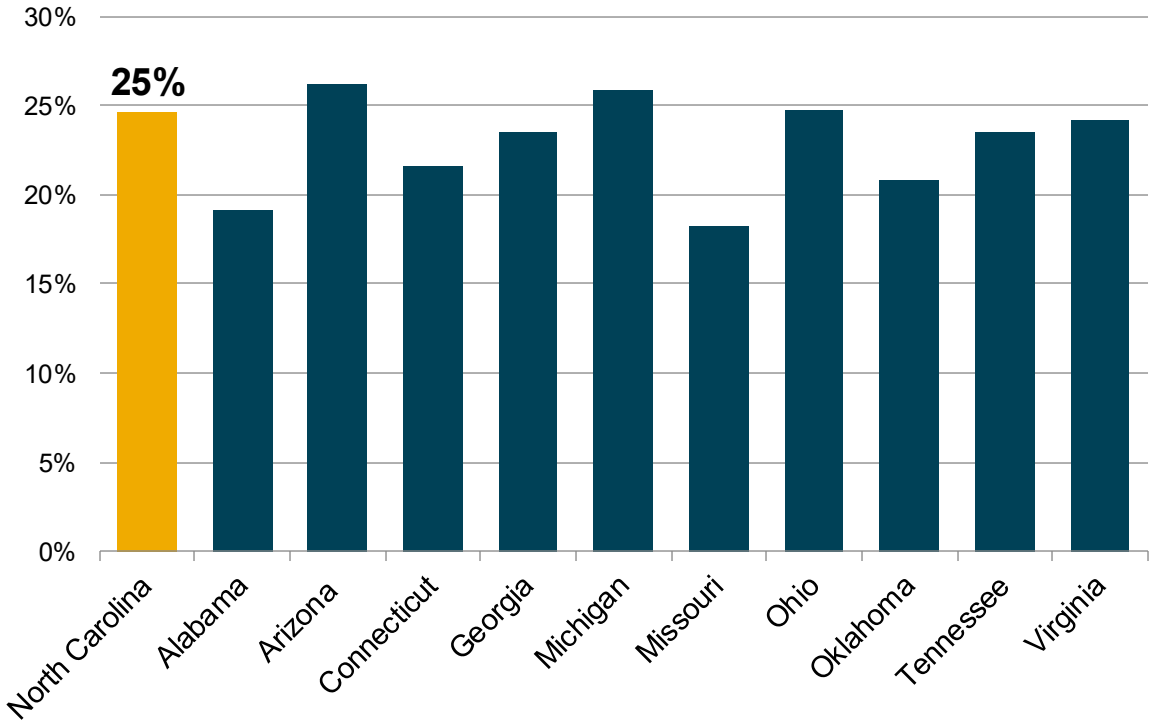
NC Has Relatively High Unmet Need for Mental Health Treatment

North Carolina had a lower rate of adult mental illness prevalence (21%) but a higher rate of unmet treatment need (25%) relative to most Peer States. Low prevalence may reflect difficulty in accessing services where a diagnosis might be made.

Share of Adults With any Mental Illness (AMI), CY 2025



Adults with AMI Reporting an Unmet Need for Treatment, CY 2025



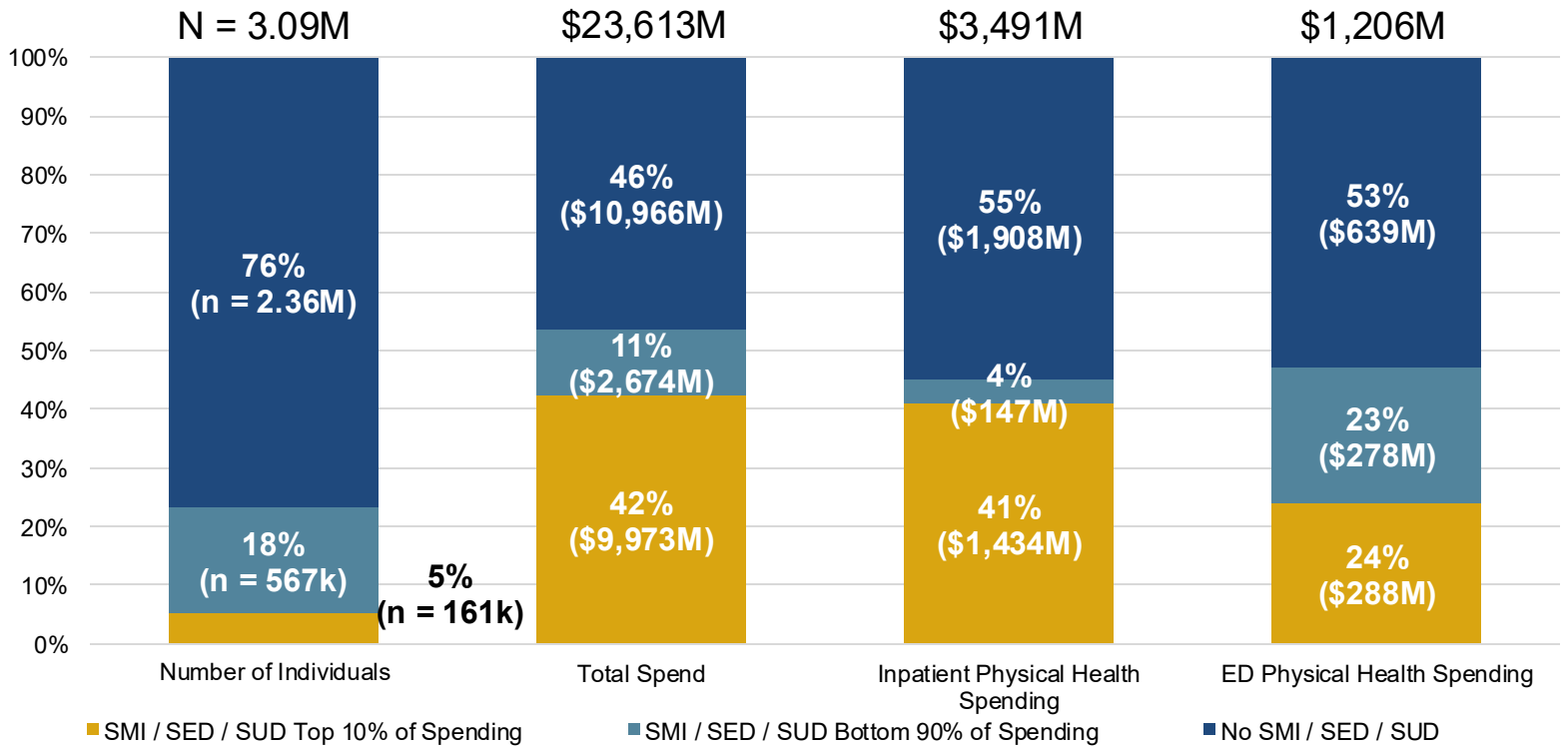
Note: MHA rankings are composite rankings based on 17 equally weighted measures across adult and youth prevalence and access. NC = North Carolina

Source: Mental Health America (MHA), State of Mental Health in America, 2025. MHA rankings reflect all North Carolinians, not Medicaid enrollees specifically.

Individuals With SMI/SED/SUD Accounted for Over Half of NC Medicaid Spending

Individuals with SMI, SED, and/or SUD accounted for a disproportionate share of total, ED, and inpatient spending on physical health conditions.

Total, Inpatient, and ED Spending Among Individuals With SMI/SED and SUD Relative to Other Medicaid Enrollees, SFY 2025



Key Considerations

- In 2025, individuals with mental illness (SMI and SED) and/or severe SUD comprised 23% of the Medicaid population but accounted for:
  - 53% total Medicaid spending, and
  - Nearly 50% of inpatient and ED spending for **physical health conditions**.
- While evidence shows that individuals with mental health disorders and SUD have worse physical health and accrue greater physical healthcare costs compared to the general population, even a relatively small decrease in inpatient hospitalizations and ED use could produce meaningful savings and improve quality of life.

Notes: This slide includes individuals with a diagnosis of SED/SMI or SUD. SMI refers to serious mental illness, SED refers to serious emotional disturbance, and SUD refers to substance use disorder. While the diagnosis list is aligned with diagnoses required for Tailored Plan eligibility, some individuals included in these data do not meet Tailored Plan eligibility criteria because they have not had the required utilization that indicates functional impairment.

Source: Analysis of Marsh-provided data.

II.c. Focus Area Findings

RB-BHT

Landscape Analysis Key Takeaways–RB-BHT

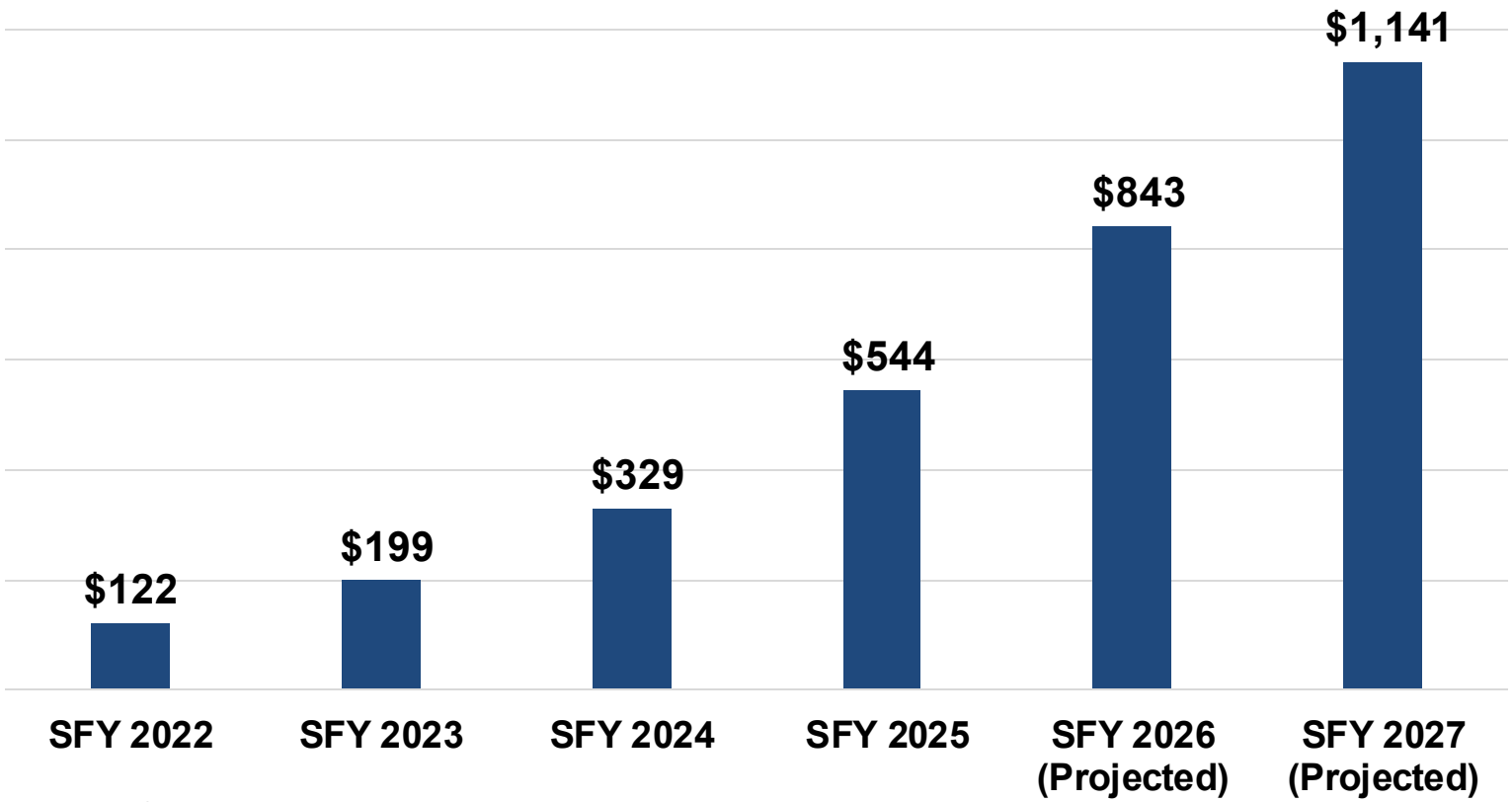
- **RB-BHT** is not a major cost center in North Carolina, but it i**s a notable cost growth driver.**
- Growth in RB-BHT **spending has outpaced growth in utilization.**
- **Spending is concentrated among a small number of providers** with five providers accounting for over 40% of spending growth from 2023 to 2024.
  - **However, North Carolina has also seen an influx of new providers entering the market** with the number of providers billing RB-BHT increasing significantly from 2019 to 2026. This could resolve long-standing access issues while also introducing new challenges.
  - While some new providers are backed by private equity, additional analysis would be needed to determine the specific impact of PE ownership on RB-BHT utilization patterns in the State.
- **Drivers of increased utilization and spending** (as identified in NCDHHS's October 2025 RB-BHT policy paper) include **lack of specificity in clinical coverage policies** and standards, **utilization of RB-BHT in lieu of less intensive therapies**, and a 15% increase in RB-BHT reimbursement rates in 2024.
- **Substantial changes—several of which are legislatively mandated—to these services are under development with the goal of ensuring efficiency and access**.

Source: NCDHHS Presentation to the Joint Legislative Oversight Committee on Medicaid (2026); NCDHHS Ensuring Person-Centered Care for Children with ASD in the NC Medicaid Program; Short Naps, Long Hours: How Autism Clinics Squeeze Medicaid Dollars Out of Preschoolers - The New York Times

NCDHHS Is Responding to Rapid Growth in RB-BHT Spending

In recent years, North Carolina has experienced rapid growth in its research-based behavioral health treatment (RB-BHT) benefit with spending projected to increase more than nine-fold between SFY 2022 to 2027.

Total RB-BHT Medicaid Spending, SFY 2022 – 2027 (in millions)



Notes: See Appendix for key policy and program actions taken to date on RB-BHT.

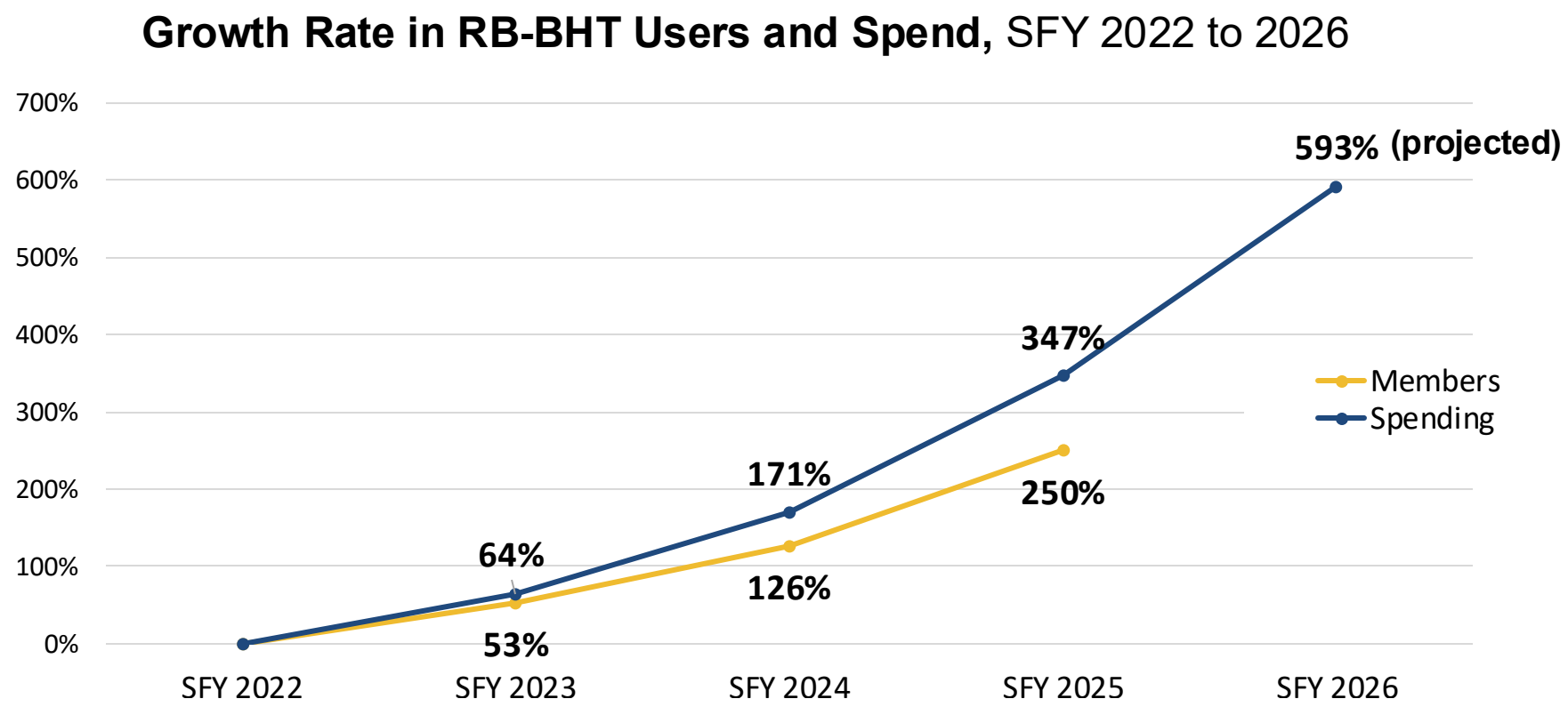
Key Considerations

- RB-BHT covers research-based treatment modalities for autism spectrum disorder that are "supported by credible scientific or clinical evidence," including Applied Behavior Analysis (ABA), which accounts for virtually all RB-BHT claims.
- Since summer 2025, NCDHHS has been reforming the RB-BHT benefit to ensure services delivered are both high-quality and medically appropriate.

Source: NCDHHS Presentation to the Joint Legislative Oversight Committee on Medicaid (2026)

The RB-BHT Spending Increase Is Driven by Higher Utilization Per Member

The average number of RB-BHT service hours delivered to beneficiaries has increased without evidence of a corresponding increase in the level of need or symptom severity among enrollees.



Key Consideration

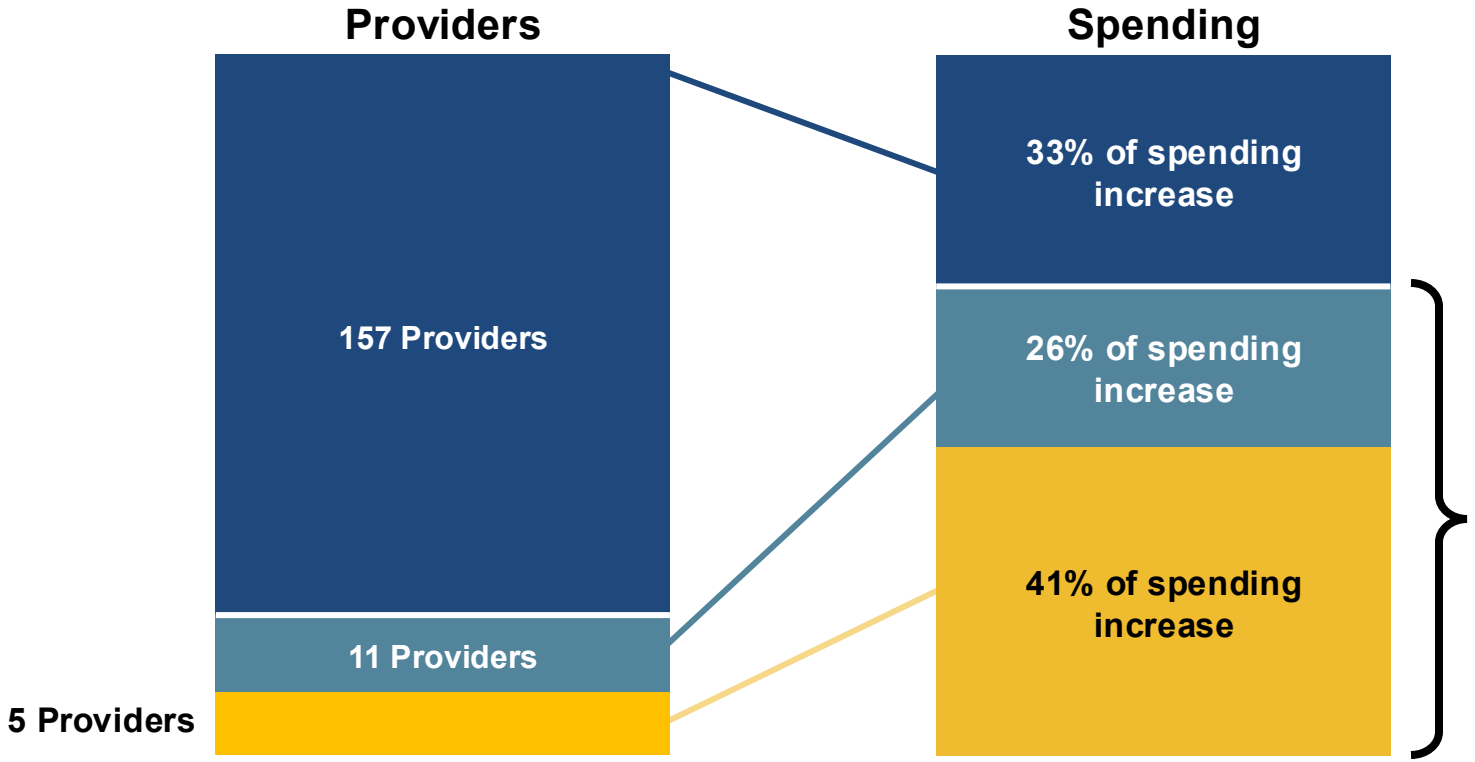
- Between SFY 2022–2024, the median number of RB-BHT hours a North Carolina Medicaid enrollee received per month increased from 41.3 hours to 48 hours.
- This represents a substantial increase in hours of services provided to enrollees although there is no evidence that beneficiaries with ASD are experiencing an increase in the severity of their ASD-related symptoms.

Source: NCDHHS Presentation to the Joint Legislative Oversight Committee on Medicaid (2026); NCDHHS Ensuring Person-Centered Care for Children with ASD in the NC Medicaid Program

A Small Number of Providers Are Driving Much RB-BHT Spending Growth

Five providers statewide are responsible for 41% of the spending increase between SFY 2023 and SFY 2024.

Share of RB-BHT Spending Increase by Billing Provider,
SFY 2023 to 2024



Key Consideration

- At least half of the 16 providers responsible for 67% of the spending increase in SFY 2023 – 2024 had PE backing. Others have been acquired by PE since then.

Source: NCDHHS Ensuring Person-Centered Care for Children with ASD in the NC Medicaid Program; Manatt analysis of Marsh provided NCDHHS data on RB-BHT spending.

II.c. Focus Area Findings

Managed Care

Landscape Analysis Key Takeaways–Managed Care

- **Eighty-one percent (81%) of individuals in North Carolina Medicaid are now enrolled in managed care** as of June 2026, the vast majority of which are in a Standard Plan.
- Consistent with experiences reported in other states and NCDHHS projections, available data suggest that implementing **managed care in North Carolina has not significantly reduced overall state Medicaid spending**.
  - **Benefits spending per enrollee is lower in Standard Plan managed care** relative to fee-for-service, but these **savings are offset by non-benefit spending**, including administrative costs, care management, and underwriting gain/profit.
- Evidence remains mixed on whether introducing managed care improved experience and quality metrics.
  - **Providers** generally report worse experiences with Standard Plan managed care compared to fee-for-service, highlighting opportunities to improve managed care administration.
  - The performance on **member experience** is mixed: Some experience scores for children were higher in managed care than fee-for-service (FFS), but adults generally reported worse experiences in managed care than in FFS.
  - **Quality measure** performance is generally higher for Standard Plans than FFS, but differences in the populations likely contribute to that difference.
- This analysis focused primarily on the Standard Plans because data on Tailored Plans remains limited since the 2024 launch.

Non-Benefit Costs Largely Offset NC Managed Care Medical Savings in SFY 2024

While medical expenses are estimated to be lower for members who are enrolled in managed care compared with FFS, non-benefit costs largely negates those savings.

Comparison of SFY 2024 Standard Plan Non-Expansion Managed Care Costs to Estimated FFS Costs
(Marsh Analysis)

Expense	Managed Care PMPMs	Estimated FFS Equivalent PMPM^	Total Cost of Managed Care v. FFS (Est., PMPM)	Total Cost of Managed Care v. FFS (Est.)
Total Medical	$335.40	$373.46	($38.06)	($829,400,000)
Non-Benefit Costs^^	$38.38	N/A	$38.38	$836,200,000
Premium Tax	$7.39	N/A	$7.39	$161,000,000
Total	**$381.17**	**$373.46**	**$7.71**	**$167,800,000**

^ FFS equivalent is a hypothetical projection of CY 2019 base data for the same population and services as included in managed care with relevant adjustments for trend and programmatic changes to align with SFY 2024. ^^ Non-benefit costs are added to the medical/benefit cost to calculate the managed care capitation amount. These include general admin expenses, care management, and underwriting gain/profit for activities performed by the PHPs. These figures do not contemplate any costs associated with State administrative activities under either scenario, including any previously negotiated PCCM fees that pre-dated managed care launch.

Notes: Premium taxes levied by North Carolina on all insurers are accounted for in capitated rates and are a managed care cost to the state relative to fee-for-service. However, revenues generated from the premium tax accrue back to the State General Fund, supporting programs and initiatives beyond Medicaid. Additionally, these figures are illustrated on a total computable basis and do not consider any impact of pharmacy rebates or separate payment terms paid to health plans outside of capitation.

Source: Analysis of Marsh-provided data, "Value of Managed Care Analysis – DRAFT," July 31, 2025; Yale Tobin Center for Economic Policy, "Privatizing Medicaid Saved Money—Almost Entirely on Prescription Drugs, Not Medical Care" policy brief, August 2026.

Managed Care Plan Members Do Not Report Better Member Experience Than FFS Members

Although managed care plans generally offer more customer service features, members do not report an improved member experience compared with FFS.

Positive Member Responses on the Consumer Assessment of Healthcare Providers and Systems, Surveyed Feb. to May 2024

	Overall NC Medicaid Program (FFS + Managed Care)		Standard Plans	
	Adult	Child	Adult	Child
Global Ratings: *% who gave 8+ out of 10 rating*				
Rating of Health Plan	79.4%	86.2%	75.9%	86.5%
Rating of All Health Care	77.5%	86.6%	75.9%	86.5%
Composite Measures: *% who said "usually" or "always"*				
Getting Needed Care	86.1%	87%	81.9%	86.6%
Getting Care Quickly	84.6%	89.2%	82.0%	88.8%
Customer Service	91.4%	87.6%	87.3%	87.5%
Individual Item Measure: *% who said "usually" or "always"*				
Coordination of Care	87.6%	88.0%	84.4%	88.2%

Key Considerations

- When compared with national NCQA percentiles, the North Carolina Medicaid Program overall (inclusive of both managed care and FFS) is at or over the 50th percentile on most measures of member experience.
- Standard Plans performed *worse* than FFS across key measures of adult member experience.
- Standard Plans performed slightly *better* than FFS in some key measures of child member experience.

Source: Manatt analysis of 2024 Adult and Child Medicaid Consumer Assessment of Healthcare Providers and Systems Aggregate Report.

II.c. Focus Area Findings

Administration & State Operations

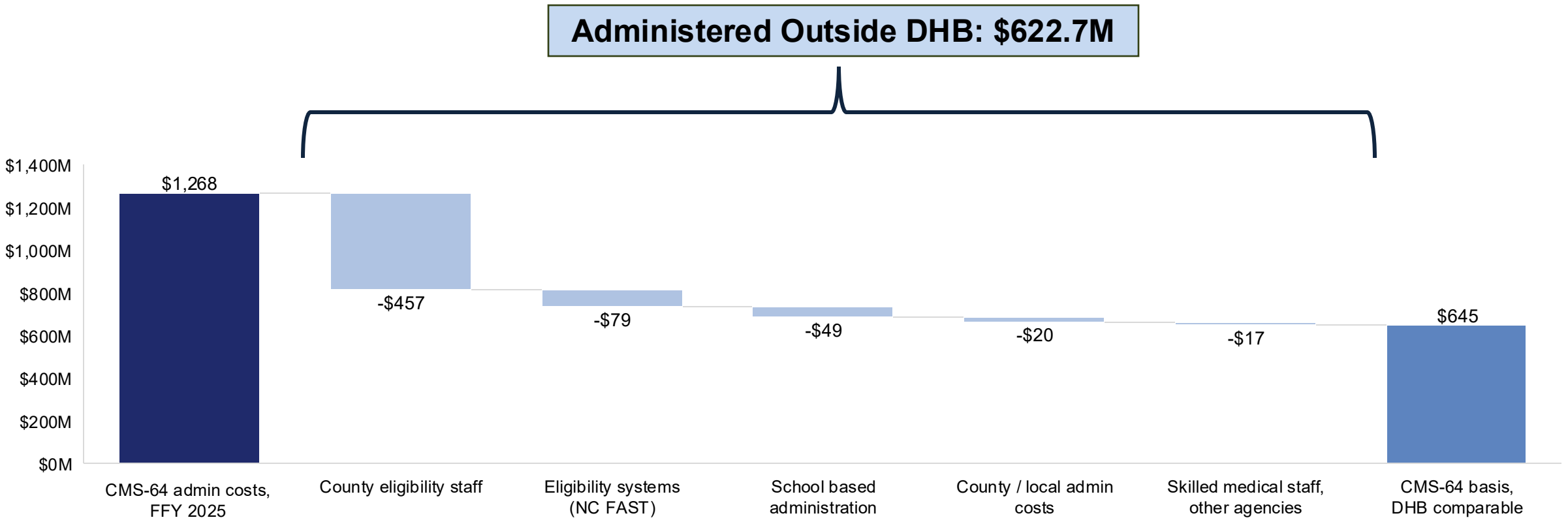
Landscape Analysis Key Takeaways–Administration & State Operations

- **Administration and state operations is not a main cost center or cost driver for NC Medicaid**.
- While the state **spends more per enrollee on administrative services than most Peer States**, much of the difference is attributable to its higher spending on its local, county-based Eligibility & Enrollment (E&E) functions and services (a model shared with seven other states).
  - **North Carolina spends more than twice the amount per enrollee on E&E functions and services** than Peer States, yet application and renewal processing timeframes generally lag national benchmarks. North Carolina reports strong *ex parte* renewal performance.
- **North Carolina has a leaner state (DHB) Medicaid workforce than most Peer States** (1.5 FTE per 10,000 Medicaid members in North Carolina v. 4.9 FTE per 10,000 in Peer States).
  - For example, the state's managed care team is notably understaffed. While 80% of NC Medicaid is delivered through managed care, the state only has 10 full-time equivalents (FTEs) focused on plan administration and oversight. Other teams have been expected to undertake managed care-specific responsibilities on top of their historical workload.
- **North Carolina Medicaid's contractor spending has grown** in recent years as the state transitioned to managed care and expanded its Medicaid program.
  - In response to FTE freezes and reductions, DHHS has had to rely on contractor support to implement new initiatives (including managed care) and to administer an increasingly complex program.
- **Managed care has introduced a new type of Medicaid administrative spending**. Standard Plans and Tailored Plans are expected to expend over $1.15 billion in administrative services to support care delivery for their members in SFY 2027.

Notes: MMIS = Medicaid Management Information System.

Half of NC Medicaid's Administrative Expenses Reside Outside of DHB

Half of Medicaid administration expenditures (~$623 million) reside outside of the Division of Health Benefits, including at the county level where county eligibility staff accounted for $457 million of expenditures in FFY 2024.



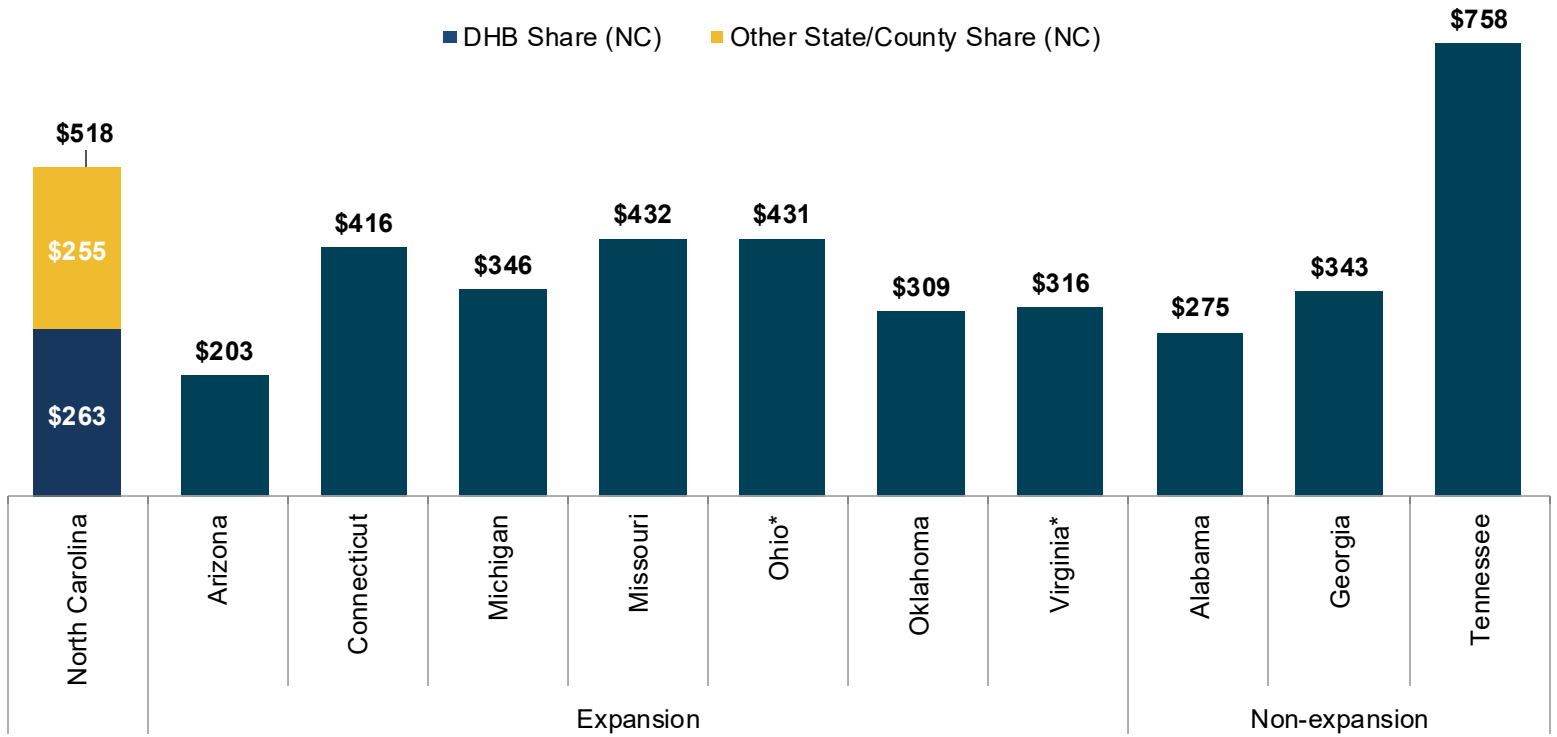
Notes: MBES Financial Management Report, net administrative expenditures, total computable, federal FY 2025 (certified; CMS has not yet published the FY 2025 FMR, and later prior period adjustments may revise figures). Income statement: BD701 actuals, budget code 14445, state FY 2026. Cost allocation within the $410.0M and Other Financial Participation line pending working paper verification. "CMS-64 net admin" expenditures reflect Medicaid administrative expenditures reported by the State to CMS through the CMS-64/MBES financial reporting process. The "CMS-64 basis, DHB comparable" column reflects the expenditures remaining after removing non-DHB expenditures from these administrative expenditures.

Source: NCDHHS provided analysis.

NC Spends More Per Enrollee on Medicaid Administration Than Peer States

North Carolina Medicaid's statewide administrative spending per enrollee is higher than all Peer States except Tennessee.

Medicaid Total Administrative Spending Per Enrollee, FFY 2024

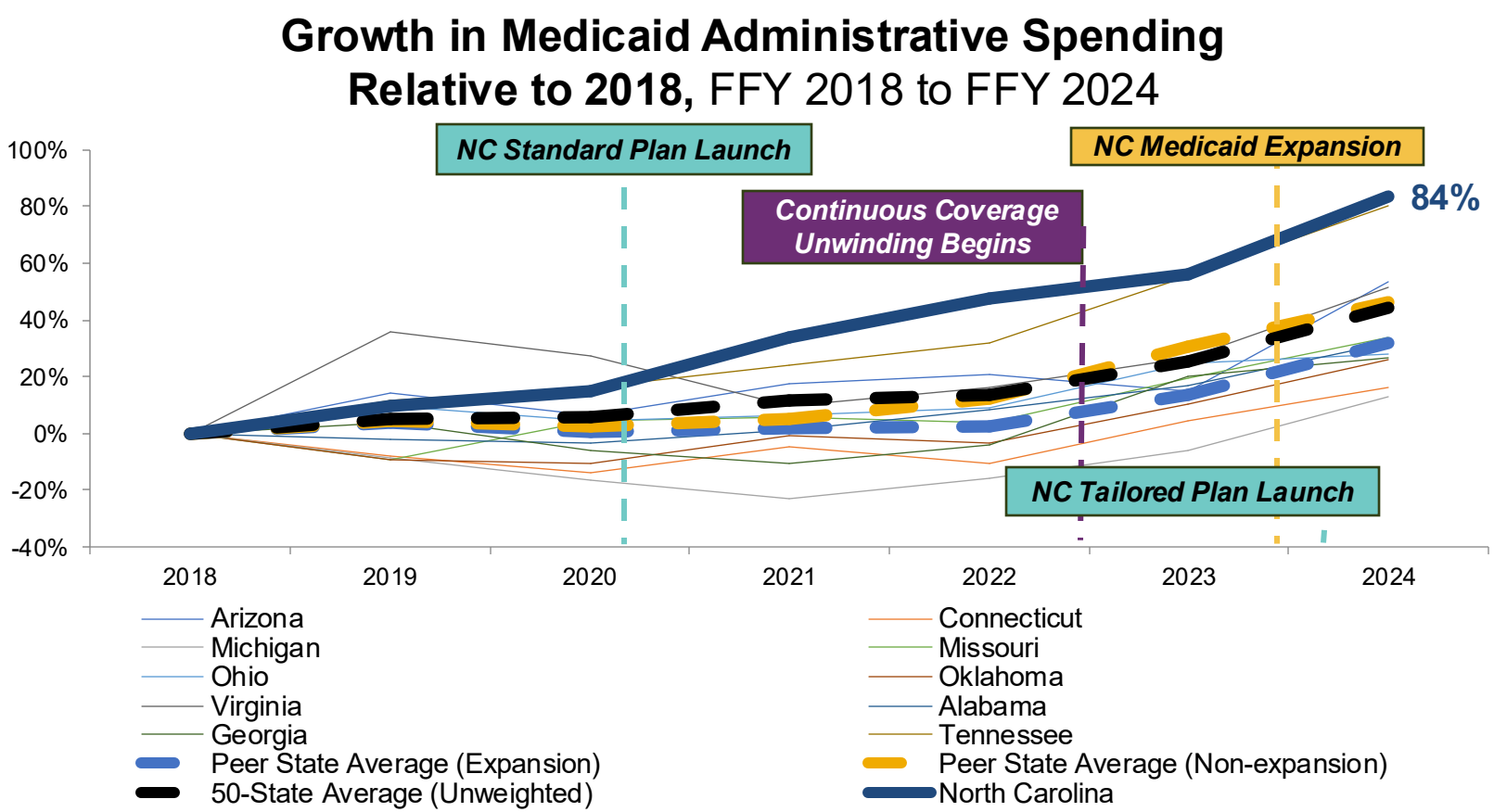


State	Per-Enrollee Total Admin Spend (FFY 2024)
Tennessee	$758
North Carolina	**$518**
Missouri	$432
Ohio	$431
Connecticut	$416
Michigan	$346
Georgia	$343
Virginia	$316
Oklahoma	$309
Alabama	$275
Arizona	$203

Source: MACPAC MACStats Exhibit 31 analysis of CMS-64 MBES reports; MACStats Exhibit 15 and analysis of T-MSIS Analytic Files.

NC Medicaid Administrative Spending Has Grown Faster Than Peer States

North Carolina Medicaid's statewide administrative spending grew faster than Peer States from 2018 to 2024 as it implemented managed care and expanded Medicaid.



State	Administrative Service Spending	
	FFY 2024	Change (FFY18-24)
North Carolina	**$1,326,183,162**	**84%**
DHB^	$674,596,325	-
County/Other^	$651,586,837	-
Tennessee	$1,119,126,043	80%
Arizona	$421,844,720	54%
Virginia	$570,877,479	51%
Missouri	$553,664,414	34%
Alabama	$292,879,626	32%
Ohio	$1,215,044,711	28%
Georgia	$707,046,708	26%
Oklahoma	$285,224,906	26%
Connecticut	$459,781,036	16%
Michigan	$901,446,369	13%

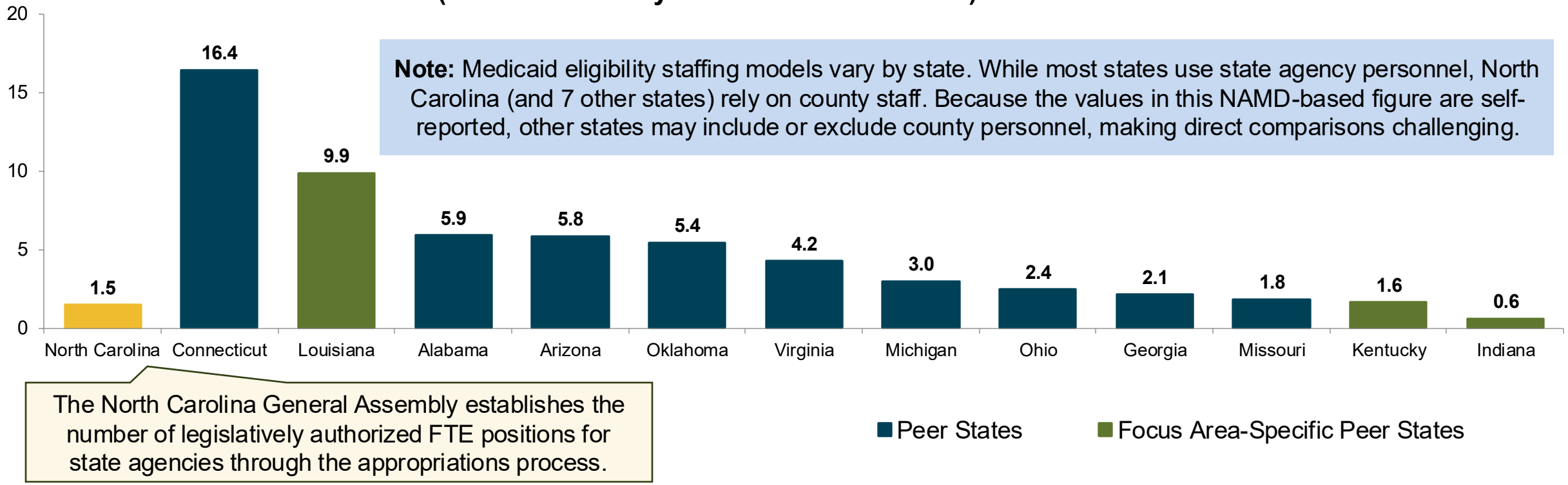
Notes: FFY = Federal Fiscal Year. North Carolina expanded Medicaid in December 2023. Administrative spending includes expenditures related to state eligibility systems, MMIS, EHR incentive programs, and other administrative functions. Peer State averages are unweighted. Administrative spending in this figure includes county spending on eligibility systems. ^Values for North Carolina assume that approximately 51% of total administrative spending is attributable to DHB (corresponding to "CMS-64 basis, DHB comparable" grouping on previous slide).

Source: MACPAC MACStats Exhibit 31 analysis of CMS-64 MBES reports.

NC Medicaid Has Lower Medicaid Agency Staffing Than Peer States

Based on currently available data, it appears that North Carolina Medicaid has among the lowest number of state agency staff per enrollee across Peer States.

Total Number of State Agency Staff per 10,000 Enrollees, SFY 2025
(Excludes County Staff in North Carolina)



Note: Medicaid eligibility staffing models vary by state. While most states use state agency personnel, North Carolina (and 7 other states) rely on county staff. Because the values in this NAMD-based figure are self-reported, other states may include or exclude county personnel, making direct comparisons challenging.

The North Carolina General Assembly establishes the number of legislatively authorized FTE positions for state agencies through the appropriations process.

Notes: North Carolina expanded Medicaid in December 2023. Agency staff include full-time and part-time employees and contractors employed in the state's Department of Health and Human Services (or equivalent agencies). Peer State averages are unweighted. Data are self-reported and do not include responses from states that did not submit a response to the staffing question: "As of July 1, 2025, how many individuals does the single state Medicaid agency employ in the following categories?" Other states operating a county-based staffing model include: California, Colorado, Minnesota, North Dakota, Ohio, South Carolina, and Virginia. Eight other states use a hybrid state-county model. SFY = State Fiscal Year, with data as of July 1, 2025.

Source: National Association of Medical Directors (NAMD) and KFF Staffing Survey. Modernizing Medicaid Eligibility: How to Reduce Hidden Friction in County-Administered States - California Health Care Foundation.

III. Proposed Policy and Program Actions

III.a. Approach and Overview

NC Evaluated and Proposed Policy & Program Actions

The North Carolina Medicaid Assessment evaluated and proposed policy and program actions that could address findings revealed in the Landscape Analysis.

Brainstorming Actions

Through discussion with national and state experts, a large set of options were considered to identify actions for further evaluation.

Evaluating Actions

NCDHHS evaluated actions against guiding principles, considering best practices, literature, and other state examples.

Proposed Policy and Program Actions

NCDHHS collected stakeholder input and conducted an implementation analysis on the Actions included in this Report.

NCDHHS considered each of the actions identified under House Bill 696 in this approach.

Guiding Principles Drove NC's Proposal of Actions

The North Carolina Medicaid Assessment sought to identify value-enhancing actions. Actions were evaluated based on five guiding principles.



Ensure access to care: Ensure people eligible for Medicaid can access coverage and timely care that meets their needs and provides a positive member experience.



Drive whole-person health: Promote positive health outcomes, safety, and well-being through a well-coordinated and high-quality system of care.



Ensure good stewardship: Optimize program administration, slow cost growth, address cost drivers, and enable a high performing program.



Support program sustainability: Avoid short-term fixes that could lead to negative down-stream impacts.



Emphasize achievability: Ensure feasibility by considering state burden, resources, and authority for adoption, and building on and learning from existing state initiatives.

Implementation Analysis Identified Authorities, Timing, and Resource Needs

For each proposed action, the North Carolina Medicaid Assessment analyzed the key operational needs and timing associated with implementation and the expected impact of each action, considering:

Earliest potential **implementation date** (budget biennium), assuming timely approval of required resources and authorities and completion of operational needs.

Resource Approval → **Program and Policy Design** → **Authority Approval(s)** → **Market Readiness and Adoption** → **Execution** → **Impact**

Resources required **to advance and implement** effectively.

Needed changes to existing **state and federal authority or** NCDHHS **contract or policy**.

Guidance, market education, technical assistance (TA), and/or convening to facilitate action adoption.

Further stakeholder engagement throughout

Interpreting the Expected Impact for Each Action

The implementation analysis also considered the expected impact of each proposed action. Three dimensions were considered: the potential for value, the resources needed, and costs to NC Medicaid.

Preliminary Expected Impact of Effective Implementation		
Value Impact	**Resource Needs**	**Cost Impact**

Expected non-financial benefit over time, such as improvements to:
• Health outcomes
• Member, provider, and PHP experience or burden
• Service utilization
• Program efficiency or sustainability
	• New or additional funding or staff needed,^ rated as:
	  ○ **Low:** <$2 million total computable/year
	  ○ **Medium:** $2 – 10 million total computable/year
	  ○ **High:** >$10 million total computable/year
	• Whether resources are expected to be upfront/time limited and/or ongoing
		Whether the action is:
		• **Likely to be cost saving**
		• **Likely to be cost neutral**
		• **Likely to increase costs**
		• **Unclear**
		Note: cost impacts were considered over the long-term and may take time after implementation to be realized.

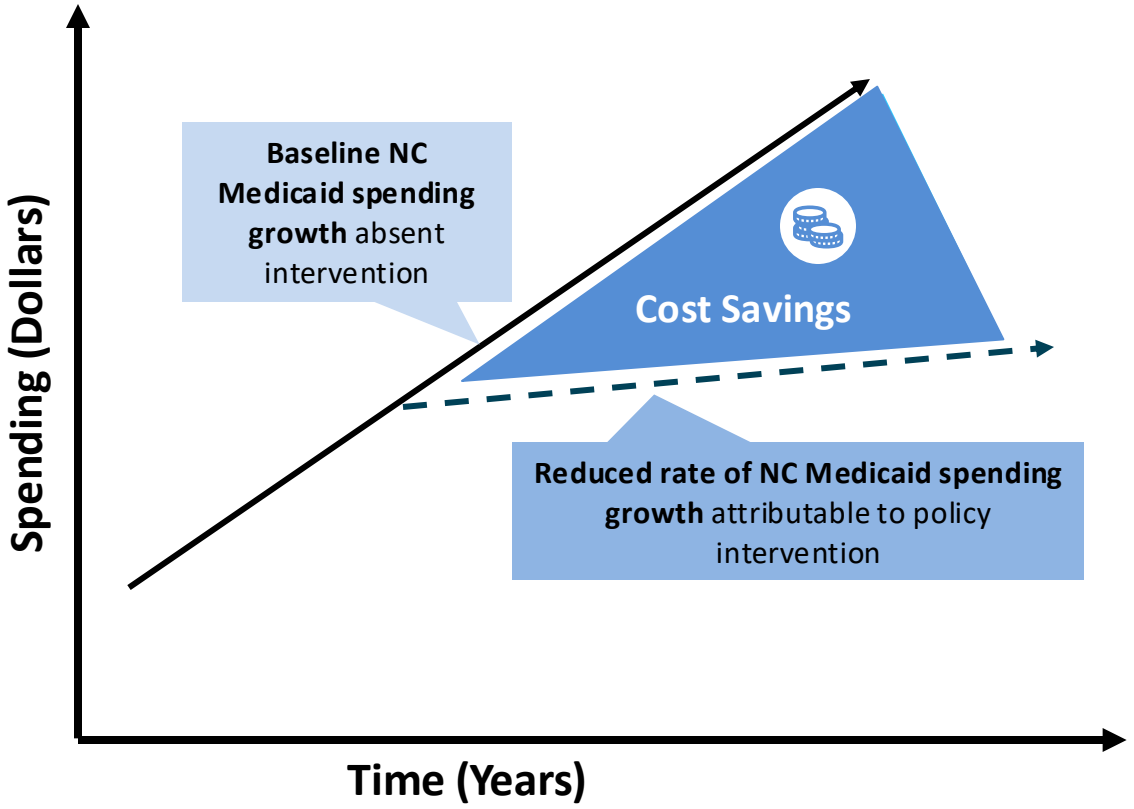
Key:	**Positive** (i.e., improved value, low resources, cost savings or cost neutral)	**Of note** (i.e., value concerns, medium or high resources, cost increases)	**Unclear** (i.e., impact unknown)

^ Funding or staff needs for things such as investments, system changes, policy or program design changes, investments in system changes, capacity building and implementation (i.e., technical assistance and training), monitoring and oversight costs, and vendor contract.

How Potential Cost Impact Was Considered

For each action, the preliminary expected cost impact was considered based on the difference between projected costs in North Carolina Medicaid absent policy intervention, and projected costs with the policy in place over time.

Illustrative Example of a Cost Saving Action



Factors Considered to Assess Cost Impact

The estimated overall net cost impact in the long term, based on:

- New or additional resource needs
- Cost offsets expected due to:
  - Reduced rates of benefit or administrative spending growth
  - Improvements in health outcomes and lower rates of adverse events (e.g., inpatient hospital admissions)
  - Increased use of more cost-effective services
  - Lower prices for targeted services

III.a. Focus Area Actions & Implementation Analyses

III.b. Focus Area Actions & Implementation Analyses

Hospital Services

Action #1: Strengthen Outpatient Hospital Payment Methodology

Description

Improve consistency and transparency of outpatient rates across hospitals, increasing the state's ability to drive program outcomes.

- Transition the outpatient hospital fee schedule away from percent of charges and instead base rates on a stable, modern methodology, such as Enhanced Ambulatory Patient Groups (EAPGs).
- Encourage or require managed care plans to adopt the state fee schedule.

Considerations

- **Hospital charges often bear little relationship to hospitals' actual costs** and can differ widely across hospitals, with variable ties to patient acuity and resource intensity.
- Setting payment levels based on charges **reduces DHB's ability to incentivize** specific outpatient services that are aligned with **policy priorities**, such as primary care and behavioral health.
- Transitioning to an outpatient prospective payment system would standardize service prices across hospitals and allow DHB to **better incentivize high-value care** based on the needs of the Medicaid population.

Many states use EAPGs for outpatient hospital payments:



Virginia: Adopted in January 2014 (VA-14-02)



Illinois: Adopted in July 2014 (IL-14-0014)



Florida: Adopted in July 2017 (FL-17-0008)



Ohio: Adopted in August 2017 (OH-17-032)

States that have switched to EAPGs often **use payment modifiers to incentivize specific policy priorities**. E.g.:



DC Medicaid includes a 25% add-on for pediatric services to encourage investment in pediatric care.



Florida Medicaid uses a policy adjuster to increase payments to rural hospitals.

#1. Strengthen Outpatient Hospital Payment Methodology

Implementation Considerations

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2–10 million total comp/year)*	**Likely Cost Neutral**
Increased control over rate incentives to **drive state policy priorities**.	• **One-time funding** for **system updates** and possible purchase of EAPG grouper software. • **Time-limited staff capacity (and/or contractor support)** to implement methodology change.	While this would serve as a more rational approach to rate setting, it would be **unlikely to drive major cost savings**.

Other Implementation Considerations	
Authority changes required	• **SPA** • **Expanded or new vendor contracts** to implement methodology. • *Mandating use of EAPGs by managed care plans would also require a new SDP preprint, rate certification updates, and managed care contract amendments.*^
Medium term implementation is feasible	• Implementation timeline is **SFY 2030–2031**. • Need for design, stakeholder engagement, SPA (and potentially SDP), contract amendment, and system updates.
Stakeholders expressed mixed feedback	• Multiple hospitals and the state hospital association opposed this proposal, noting that the transition would increase administrative burden and re-allocate payments across hospitals without lowering overall costs. • One hospital recommended NCDHHS publish a provider impact analysis and demonstrate payment stability and budget neutrality before implementing, as well as allow for sufficient implementation timelines and testing periods. • The state health plan association supported this action and indicated it would significantly simplify hospital billing and contracting.

Notes: SPA = State Plan Amendment; SDP= State Directed Payments.

^H.R. 1 and CMS rule provisions will add complexity to incorporating into an SDP. Feasibility in managed care will generally depend on CMS's final rulemaking on H.R. 1's SDP provisions.

Action #2: Make Payments Site-Neutral for Some Outpatient Services

Description

Equalize rates for certain outpatient services across settings to slow cost growth and incentivize care in the community.

- Implement site-neutral rates across outpatient hospital, ambulatory surgery centers (ASCs), and clinic settings across both FFS and managed care.^
- Consider targeted implementation to maintain access:
  - Exempt certain services to **preserve specialty access** (i.e., limit to evaluation and management (E&M), primary care, and select diagnostic/imaging services); consider leveraging savings to rebalance primary care rates across hospital and community settings.
  - **Exempt critical access, rural, and safety net hospitals**.

Considerations

- **Hospital services are currently the largest driver of NC Medicaid costs and cost growth**.
- Site-neutral payments could **slow the rate of payment growth for outpatient hospital services** and potentially steer outpatient utilization into community settings, depending on how the policy is designed.
- **Site-neutral payment policies have been adopted in several states and have been introduced in North Carolina**:
  - HB 727 would generally limit Medicaid facility fees to hospital campuses, facilities with an ED, and ASCs.
  - SB 316 would extend restrictions to outpatient E&M and DHHS-designated diagnostic/imaging services.
- This change would need to be considered in the context of payment reductions under H.R. 1.

No state has implemented broad site-neutral payment policies for Medicaid, **but several have adopted targeted policies for routine outpatient services**:

- **Connecticut (2024)**: Bans outpatient E&M facility fees with carve-outs for oncology, obstetrics, transplant, anticoagulation, orthopedics, wound care, ED services, and observation stays.
- **Colorado (2024)**: Bans preventive services facility fees with exemptions for critical access hospitals, sole community hospitals, rural providers, and Denver Health.
- **Ohio (effective 2028)**: Bans facility fees for primary care at practices purchased by hospital systems.

^Site-neutral payments would be easier to establish across professional services (v. hospital services) prior to the winddown of HASP.

#2. Make Payments Site-Neutral for Some Outpatient Services

Implementation Considerations

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2 – 10 million total comp/year)*	**Cost Impact Unclear**
Rate incentives would likely **shift care into community settings.**	• **Upfront funding** for **system updates.** • **Time-limited staff capacity** to **implement** methodology change. • **Time-limited contractor support** for **design** and implementation.	**Potential cost savings**—resulting from reductions in hospital rates—would **depend on policy design**, e.g., scope of services selected and new payment levels for affected services.

Other Implementation Considerations	
Authority changes required	• **SPA** • **Expanded or new vendor contracts** to implement methodology. • *Mandating site-neutral payments in managed care would also require a new SDP preprint, rate certification updates, and managed care contract amendments.^* • *Legislative mandate recommended.*
Long term implementation is preferred	• Recommended implementation timeline is **SFY 2032+**. • Need for design, stakeholder engagement, SPA (+ potentially SDP), contract amendments, and system updates. • *Given Medicaid hospital payments are expected to decline during this period, due to H.R. 1 cuts and the fact that this proposed action could also lower hospital reimbursement, a later implementation date is recommended to avoid further disruption.*
Stakeholders expressed mixed feedback	• Multiple hospitals and the state hospital association raised opposition to site-neutral payment policy, citing concerns that hospital outpatient clinics have materially different costs of care and reimbursement reductions could impair their ability to maintain services, particularly in underserved communities. • The state health plan association strongly supported this action as a tool to focus reimbursement on quality of care instead of care setting.

^H.R. 1 and CMS rule provisions will add complexity to implementation, and feasibility generally will depend on CMS's final rulemaking on H.R. 1's SDP provisions. A preprint may be required but will also depend on the specifics of the methodology and of CMS's final rule.

III.b. Focus Area Actions & Implementation Analyses

Prescription Drugs

Action #3: Carve Pharmacy Benefit out of Managed Care

Description

Carve the retail pharmacy benefit out of Managed Care and into FFS to better manage overall pharmacy costs and utilization.

- The state would administer a single pharmacy benefit for both Managed Care and FFS enrollees.
- This policy would not apply to the medical pharmacy benefit.

Ensure the state's pharmacy benefit administrator leverages modern technology, AI, and statistical programming when implementing the carve-out, including to:

- Streamline and generate robust reporting (e.g., on population- and patient-level data, prescribing anomalies, potential fraud, waste, abuse).
- Establish a data feed or portal that provides managed care plans with near-real-time pharmacy claims data.

Considerations

- By carving the pharmacy benefit out of Managed Care, the state would have complete control of the pharmacy benefit. This would allow the state to:
  - **Maximize efficiency** by 1) paying for 340B-acquired drugs at the ceiling price and 2) reducing disputes with manufacturers over 340B-claims so the state can secure Medicaid rebates on Medicaid-dispensed drugs.
  - **Create savings by eliminating administration and margin paid by the state** on managed care plan rates. Savings may be partially offset by new costs incurred by the state, including an expanded contract with the state's PBA.
- An alternative to carving out the pharmacy benefit is to consider a single PBA model.

New York: Budgeted savings of over $400 million in the first year following carving pharmacy benefit out of managed care.

West Virginia: Budgeted savings of over $54 million in the first year following carving pharmacy benefit out of managed care.

#3. Carve Pharmacy Benefit out of Managed Care *Implementation Considerations*

Preliminary Expected Impact

Increased Value Expected	High Resource Needs *($5–6 million one-time cost; $17–19 million total comp/year)*	Likely Cost Savings (to Medicaid) but Increased Costs (to State Overall)
• Increased control over pharmacy benefit to drive **efficient management of the program**. • **Reduced administrative burden for providers**.	• **Upfront funding** required for initial **implementation**. • **Ongoing funding** to expand **vendor contract** to manage the pharmacy benefit. • **Ongoing staff capacity** required to **implement**, including potentially hiring an additional pharmacist.	• ***While this would be cost saving to North Carolina Medicaid it would be a cost to the State overall;*** *lowered plan capitation rates would reduce the revenue generated by the premium tax, which flows into the state general fund.* • **Cost savings to North Carolina Medicaid are associated with reduced** PHP capitation **rates and administrative savings** through reduced 340B disputes.

Other Implementation Considerations

Authority changes required	• **NC General Statute 108D-35 amendment** to modify PHP benefit coverage. • **1115 waiver amendment** and **SPA** to carve pharmacy out of Medicaid managed care. • PBA **contract expansion** to manage pharmacy benefit.
Medium term implementation is feasible	• Implementation timeline is feasible by **SFY 2029–2031**. • Need for budget authority, statute and waiver amendments, SPA, and contract amendment.
Most stakeholders supported	• Most stakeholders supported this action, citing reduced administrative burden as a benefit. • Stakeholders noted that the approach to implementation would be important to prevent gaps in treatment. • Health plans opposed this action, arguing that lost premium tax revenue and managed care efficiencies will offset potential Medicaid savings. They also suggested other states that carved out pharmacy benefits encountered access, coordination, pharmacy reimbursement challenges, and administrative complexity. • *Note: In response to stakeholder feedback, NCDHHS is considering a single PBA model as a potential alternative to this policy action.*

Action #4: Connect Enrollees Prescribed GLP-1s to Supports

Description

Maximize benefits of GLP-1s by providing nutrition-related supports to enrollees.

- Require PHPs to ensure enrollees who are prescribed GLP-1s are connected to evidence-based nutrition, weight loss, and lifestyle management programs and other supports for obesity treatment.
- Require Care Management entity for FFS enrollees to make the same connections for those enrollees.

Encourage managed care plans to test digital behavior/lifestyle modification programs and remote monitoring devices (e.g., smart scales, wearables, etc.) for GLP-1 users, with reporting requirements to DHB on key learnings, best practices, and member outcomes.

Considerations

- **GLP-1 medications are a significant cost driver for pharmacy spending,** accounting for 15% of pharmacy spending growth between 2019 and 2025.
- Nutrition-based supports and evidence-based nutrition, weight loss, and lifestyle management programs could **help to sustain the therapeutic benefits of GLP-1s**, resulting in better outcomes and cost savings to the state in the long run.
- PHPs could **leverage existing** programs, such as HOP, to enable supports reimbursable under Medicaid.
  - Alternatively, PHPs could connect enrollees to existing community services or offer these as value-added services or as part of their reinvestment activities.
- Clinical guidelines from WHO, American Gastroenterological Association, American Diabetes Association, and American Association of Clinical Endocrinology recommend that GLP-1 therapies be combined with behavioral therapy or comprehensive lifestyle interventions, though evidence of long-term success is limited.

Minnesota: Initial prescription and renewal requires documentation of participation in an ongoing reduced-calorie diet OR documentation of ongoing care by a registered dietitian nutritionist.

Wisconsin: Prescription requires physician attestation that member has participated in a weight loss treatment plan.

#4. Connect Enrollees Prescribed GLP-1s to Supports *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Low Resource Needs** *(<$2 million total comp/year)*	**Cost Impact Unclear**
• **Improved health outcomes** from lifestyle modification are likely.	• **Minimal resources**; NCDHHS already has the resources and staff needed.	• **Cost savings** resulting from lifestyle modification specifically **depend on individual utilization.** • Cost impacts of lifestyle modification specifically when paired with GLP-1s are unknown.

Other Implementation Considerations	
Authority changes required	• PHP **contract amendment** to mandate PHPs connect members to supports. • **Clinical coverage criteria update** to include connection to supports.
Near term implementation is feasible	• Implementation timeline is **SFY 2028–2029.** • Need for contract amendment and policy update.
Most stakeholders supported	• Most stakeholders supported this action. Some stakeholders noted that support services should complement treatment rather than be a barrier to GLP-1s for weight loss. • PHPs supported this action with modifications, arguing that participation in lifestyle-modification programs should be mandatory and included in the clinical criteria coverage for GLP-1s for weight loss.

Action #5: Use PBA to Manage Medical Pharmacy Benefit

Description

Introduce tools to better manage the medical pharmacy benefit to ensure appropriate use of specialty drugs across Medicaid.

- Transition management of physician-administered and outpatient hospital drugs in Medicaid FFS to the PBA.
- The state would also apply the same management protocols used for FFS to managed care.

Considerations

- **Specialty drugs are the most significant driver of prescription drug spending between 2019 and 2025.**
  - Aggregate spending on specialty drugs increased 139% while spending on non-specialty drugs only increased 66%.
- Managing physician-administered and outpatient hospital drugs would help to **ensure appropriate use of specialty drugs** across Medicaid and strengthen program stewardship when lower-cost, medically appropriate alternatives exist, and **increase the state's supplemental rebate revenue**.
  - Applying the same management protocols to managed care would maximize supplemental rebates.
- **Implementing utilization management for physician-administered drugs may create new barriers to access**.
  - NCDHHS could establish policies that prevent disruption to ongoing courses of treatment.
- While utilization management can limit provider autonomy and increase providers' administrative burden, this action would align and centralize utilization management rather than leaving to individual PHPs, which could reduce provider burden long-term.

#5. Use PBA to Manage Medical Pharmacy Benefit *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2–10 million total comp/ year)*	**Likely Cost Savings**
• **Strengthened program stewardship**. • **Appropriate utilization** of specialty drugs across Medicaid.	• **Upfront funding** to build out **vendor** benefit management platform. • **Ongoing funding** to expand **vendor contract** to manage the benefit.	• **Cost savings** associated with **introduction of utilization management and** maximizing **rebate revenue** by allowing the state to claim **supplemental rebates**.

Other Implementation Considerations	
Authority changes required	• PBA **contract expansion** to manage physician-administered and outpatient hospital drugs. • **CCP update** for PAPD to clarify that the state has the option to establish prior approval for select drugs.
Near term implementation is feasible	• Implementation timeline is **SFY 2028–2029.** • Need for budget authority, contract amendment, policy update, and vendor implementation readiness (e.g., management platform development).
Stakeholders expressed mixed feedback	• Most stakeholders supported this action or supported with modification. • Stakeholders noted that this action would reduce administrative burden by streamlining management across Medicaid and requested that access to previously approved medications be protected during the transition to PBA management. • PHPs opposed this action, noting that plans were only recently authorized to manage the medical pharmacy benefit; PHPs asked for a longer timeline to realize results. In a follow-up meeting, NCDHHS clarified with the PHPs that this action is primarily focused on FFS.

Action #6: Limit Provider Use of 340B Drug Purchasing Program

Description

Reduce administrative burden and maximize Medicaid rebates by limiting provider use of the 340B drug purchasing program.

- Prevent most providers from using 340B discounted drugs on Medicaid enrollees altogether.
- Non-hospital federal grantees, including Federally Qualified Health Centers (FQHCs); local health departments; Critical Access Hospitals (CAHs); and non-acute care hospitals would be exempt and allowed to use 340B discounted drugs for Medicaid.^

As of 2024, Wyoming,^^ South Dakota, Delaware,^^ New Hampshire, and Maine have conditional or mandatory 340B carve-outs in Medicaid.

- Wyoming, South Dakota, and Maine are primarily fee-for-service states or apply the 340B carve-out in FFS.
- Delaware and New Hampshire have high managed care penetration, but significantly fewer Medicaid members and care plans than does North Carolina.

Considerations

- Carving out 340B from Medicaid would:
  - Allow the state to **maximize revenue by claiming supplemental rebates** on Medicaid prescription drugs, potentially lowering the net cost of Medicaid pharmacy.
  - **Decrease administrative burden** by reducing the number of disputes with pharmaceutical manufacturers and reducing plan overpayment of 340B acquired products.
- The **340B program** allows covered entities to purchase 340B drugs at a discounted price; this is **essential for FQHCs/ RHCs and other smaller clinics that operate on a thin pharmacy-related budget**.
  - In the absence of 340B, providers would purchase drugs at substantially higher upfront costs, **creating cash-flow issues for smaller entities** with tight budgets.
- **There is potential for a substantial reduction in the administrative burden on state and plan staff.**

^Critical access hospitals as defined under NC § 108A-145.3(5). Hospitals that are not an acute care hospital as defined under NC § 108A-145.3(1b). See link for list of non-hospital federal grantees.
^^Entities seeking to use 340B drugs for Medicaid enrollees in these states must receive state approval.

#6. Limit Provider Use of 340B Drug Purchasing Program *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Low Resource Needs** *(<$2 million total comp/year)*	**Likely Cost Savings**
• **Reduced administrative burden on state and plan staff** through reduced 340B disputes.	• **Time-limited staff capacity** to **implement**.	• **Cost savings** from maximizing rebate revenue by allowing the state to claim **supplemental rebates** on Medicaid prescription drugs.

Other Implementation Considerations	
Authority changes required	• **SPA** to carve 340B out of Medicaid. • PHP **contract amendment** to clarify that PHPs may no longer reimburse certain covered entities for drugs purchased through the 340B program.
Medium term implementation is feasible	• Implementation timeline is **SFY 2029–2031.** • Need for stakeholder engagement, SPA, and contract amendment.
Stakeholders expressed mixed feedback	• Stakeholders raised concerns with this action, with many requesting additional entities be exempted. • Local health departments (LHDs) support is contingent on modifying this action to exempt LHDs, public health grantees (e.g., Title X, STI, and Tuberculosis clinics), and Ryan White programs. *Note: NCDHHS modified this action to exempt these additional entities.* • Hospitals opposed this action, arguing that it will undermine resources that rural and safety-net hospitals rely on to maintain services, infrastructure, and access. • Other stakeholders noted it would add burden by requiring entities to identify Medicaid patients before treatment.

III.b. Focus Area Actions & Implementation Analyses

LTSS

Action #7: Implement a Skilled Nursing Facility (SNF) Value Strategy

Description

Maximize the value of SNF investments by establishing a quality improvement and accountability program. Program would include:

- Public reporting on facility-level quality and performance measures (e.g., resident experience and outcomes and staffing metrics).
- Targeted technical assistance for underperforming facilities.
- Quality-based financial incentives (e.g., an add-on bonus) that reward facilities achieving strong performance on quality, staffing, and resident outcomes.

Explore including a health technology or AI-powered pilot program to scale remote patient monitoring (e.g., for fall prevention). This could potentially include bonus payments for early adopters or be tied to spending reductions, measured retrospectively, for participating facilities.

Considerations

- **SNF spending grew by 17% from 2021–2025, largely driven by an 89% increase in average per diem rates for long-term SNF stays**.
- During this timeframe, utilization remained largely flat while **performance lagged**:
  - 42% of North Carolina SNFs receive just 1 or 2 stars out of CMS' 5-star quality rating system based on health inspections, staffing, and quality measures, slightly above the national average.
  - The average number of fines for health & safety inspection deficiencies and average fine amount per NC facility is above the national average.
- Evidence suggests that **improvements in the clinical quality of nursing home care are achievable**, particularly through effective payment policy.
- This action would complement the SNF Cost Containment Pilot established through the SFY 2026–2027 Budget by **driving quality improvements**, though a quality-based financial incentive program may require legislative action to implement.
- The SNF Value Strategy quality measures will not rely only on STAR ratings and will be tested with stakeholders.

As of 2022, 24 states operated Medicaid nursing home value-based payment (VBP) programs; North Carolina is not one of them.

Minnesota publishes a nursing facility report card for prospective residents and families to compare SNFs, including metrics such as quality indicators, quality of life surveys, state inspection results, and direct care staff metrics.

Tennessee has established a value-based payment program that pays nursing facilities based on the performance on certain quality measures through a quality-based component of each nursing facility's per-diem rate.

#7. Implement a SNF Value Strategy *Implementation Considerations*

Preliminary Expected Impact

Increased Value Expected	Medium Resource Needs *($2–10 million total comp/year)*	Likely cost neutral
• **Reduced** or **avoided** hospital **utilization** for SNF residents. • Potentially **shortened lengths of stay** where appropriate. • **Improved** resident **health outcomes.**	• **Dedicated staff capacity** (or contractor support) for **design of** SNF quality and accountability program and **ongoing staff capacity** (or contractor support) for **monitoring** and **technical assistance.** • **Potential upfront funding** for **system updates** for new reporting. • **Ongoing funding** for a quality-based **incentive** add-on for high-performing facilities.	• **Longer-term offsets may be expected** following upfront investment.^ • **Degree of cost savings will depend on** the **design** of SNF quality program and financial incentives.

Other Implementation Considerations

Authority changes required	• **Legislative amendment** to SFY 2026–2027 Budget to pursue quality-based financial incentives.^^ • **SPA** to incorporate a quality-based rate component into the SNF reimbursement rate methodology. • **Policy updates** to establish SNF quality and incentive program requirements.
Near term implementation is feasible	• Implementation timeline is **SFY 2029 (estimated January 1, 2029)**, coinciding with the start of implementation year two of the SNF Cost Containment Pilot.
Most stakeholders supported	• Most stakeholders supported the action as proposed or with modifications, with several requesting involvement in design. • Health care facilities suggested implementing once recent methodology revisions stabilize and recommends risk adjustment and stakeholder-tested quality and performance measures given limitations with STAR ratings and penalty/citation data. • Hospitals, health systems, and providers emphasized the need to preserve and expand SNF capacity, particularly for complex patients. • Health plans recommended NCDHHS draw on best practices from SNF quality/incentive programs in other states and make parallel workforce investments. • Other stakeholders supported accessible public reporting for patients/families and extending quality-based incentives to other congregate settings (e.g., ICFs or PRTFs).

^Since 77% of SNF residents are dual-eligible for Medicare and Medicaid, most avoided ED and hospital costs associated with this action would accrue to Medicare.

^^The SNF Cost Containment Pilot currently prohibits changes to SNF reimbursement rate methodology and to total SNF State expenditures before or for the duration of the pilot (2028–2032).

Action #8: Strengthen CAP/C and CAP/DA Case Management

Description

Strengthen case management provided to CAP/C and CAP/DA waiver participants to ensure consistency in service delivery, improve outcomes and member satisfaction, and reduce unnecessary use of high-cost services like hospital and emergency department services.

- Implement improved operational practices, targeted training and technical assistance, and stronger oversight.
- Potentially reduce the number of waiver case management entities (CMEs).
- Strengthen connections to physical and behavioral health care management.
- Develop more targeted interventions (e.g., care transitions support) or an integrated care management model.

Considerations

- **Participants in the CAP/C and CAP/DA waivers are among the highest-need and highest-cost enrollees in North Carolina's Medicaid program**.
  - From 2021 to 2025, total spending for the CAP/DA waiver population increased by 47.9% even though enrollment only increased by 3.6%.
  - Per capita inpatient hospital cost was also substantially higher than other waiver participants.
- **Care management is fragmented across multiple entities** without a single point of responsibility.
- Care management **delivery is also inconsistent** across over 80 CMEs statewide.
- Effective case management models have been demonstrated to drive improvements in clinical outcomes, health care use and spending, and patient satisfaction.

Texas's 1115(a) waiver-funded care coordination reduced hospitalization risk by 19%, **saving approximately $1,500 per enrollee** annually.

Washington's Complex Discharge Pilot combined intensive care management, LTSS coordination, and flexible supports, reducing hospital LOS from 28 to 11 days, lowering 30-day readmissions by 37%, and generating an estimated **$14M in net hospital savings** across all patients served by the pilot.

#8. Strengthen CAP/C and CAP/DA Case Management *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Low Resource Needs** *(<$2 million total comp/year)*	**Likely cost neutral**
• **Reduced or avoided** emergency department, hospital, or SNF **utilization**. • **Improved health outcomes** for CAP/C and CAP/DA enrollees.	• **Additional staff capacity** required to assess the current state,^ design and implement policy and program changes, and support training and ongoing quality monitoring.	• Cost savings may be minimal due to **needs of the population.**^^

Other Implementation Considerations	

Authority changes required	• **Waiver changes** may be required:
	  ○ 1915(c) waiver amendment to update CME roles and case management requirements, if NCDHHS pursues this action separate from waiver renewals.
	  ○ A concurrent 1915(b)(4) waiver, if the state streamlines and consolidates the number and choice of CMEs.
	• Case management policy guidance and North Carolina Medicaid Provider Agreement updates to reflect changes in performance expectations and/or new requirements. Contract amendments may also be needed for Tailored Plan and Community Care of North Carolina (CCNC) contract to reflect new requirements.

Near term implementation is feasible	• Implementation timeline is **SFY 2028 – 2029**.^^^
Most stakeholders supported	• Most stakeholders supported the action as proposed. • Stakeholders recognized the action's potential to improve community-based care and outcomes while reducing hospitalizations and ED visits. • Stakeholders also maintained that success will require accountability and coordination between health plans, providers, community organizations, and caregivers, along with targeted training and stronger oversight. • The state pediatric professional association encouraged NCDHHS to engage primary care pediatricians, subspecialists, and families in the design.

^ Staff capacity needs may increase in scope and intensity over time based on the findings of the current state assessment (e.g., if the State moves toward designing and implementing an integrated care management model).
^^ Since ~80% of CAP/DA waiver participants are dual-eligible for Medicare and Medicaid, most avoided ED and hospital costs associated with this action would accrue to Medicare.
^^^ Note: If NCDHHS pursues this action as part of CAP/C waiver and CAP/DA waiver renewals beginning March 2028 and November 2029, respectively, this would push the implementation timeline for CAP/DA into SFY 2030.

III.b. Focus Area Actions & Implementation Analyses

Primary Care and Population Health

Action #9: Implement Next-Generation Primary Care Model Pilot

Description

Pilot an innovative primary care payment model that gives providers more flexibility to offer whole person care, reduce costs and improve outcomes.

- Offer capitated primary care payment to eligible rural advanced medical home (AMH) practices to replace most fee-for-service payments.
- Under the pilot, NCDHHS may also:
  - Provide performance-based incentives linked to outcomes.
  - Develop enhanced care delivery expectations (e.g., offering extended hours) for model participants.
  - Incorporate enhanced non-visit-based population payments tied to increased care delivery expectations.
  - Require PHPs to offer the model specified by NCDHHS.

Maine: MaineCare is planning to evolve its Primary Care Plus (PCPlus), a voluntary model paying primary care practices a monthly population-based payment (similar to North Carolina's AMH program), to incorporate a prospective payment model that would also replace some FFS service payments.

Massachusetts: MassHealth implemented a primary care sub-capitation model in 2023. Early evidence indicates that the model has **increased investment in primary care and resulted in more revenue stability for providers**.

Considerations

- Since 2022, North Carolina's **primary care spending has declined as a share of overall spending, despite rising rates of chronic disease**.
- Investments in primary care can reduce costs **and** avoidable utilization, as well as improve health outcomes.
- Capitated primary care payment is more predictable and can give primary care practices more **flexibility** relative to visit-based reimbursement **to invest in population health infrastructure and supports**, which can improve care coordination and accessibility of care.
  - Because of their financial constraints, rural primary care practices may benefit from a transition to a more predictable payment model.
- PHPs already must offer value-based payments (VBP) to AMH Tier 3 practices. By designing this new model NCDHHS would **provide an additional, advanced VBP opportunity.**
- This action will leverage Rural Health Transformation Program (RHTP) investments.

#9. Implement Next-Generation Primary Care Model *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2–10 million total comp/year)*	**Likely Cost Neutral**
• **Reduced** or **avoided high-cost utilization.** • **Improved health outcomes** and **primary care engagement.** • Pilot will **test impact on total cost of care.**	• **Limited** resources needed given existing RHTP funds for staff time and performance incentives through SFY 2030. • *If state increased performance incentives and/or other non-visit-based payments, additional funding could be required in SFY 2031.*	• Cost savings dependent on population health management **implementation.**

Other Implementation Considerations	
Authority changes required	• **SDP preprint** to require PHP implementation of the model and performance incentives or other non-visit-based payments. • **PHP contract amendment** to reflect model requirements and performance incentives or other non-visit-based payments.
Near term implementation is feasible	• Implementation timeline is **SFY 2028 – 2029.** • Design of new primary care pilot is already underway.
Stakeholders supported with modifications	• The majority of stakeholders supported the action as proposed or with modifications. • Community Health Centers/FQHCs are interested in participating in the model and being engaged in its design. • Stakeholders recommended adequate funding and technical support for practices, a phased implementation approach that builds on the existing AMH infrastructure, standardization across PHPs, and ensuring data is timely and accurate. • Some expressed concerns that action could increase consolidation for smaller, independent practices.

Action #10: Continue to Invest in Healthy Opportunities Pilots (HOP)

Description

Continue investing in the Healthy Opportunities Pilots (HOP).

- Re-launch a limited set of HOP services with available funding in SFY 26/27.
- Secure additional state share funding to sustain HOP beyond existing time-limited funding.
- Prioritize HOP services with the strongest track record of positive impact on health outcomes and health care costs (e.g., healthy food) for a specific population (e.g., individuals with diabetes).
- Explore opportunities to expand HOP program reach in future state fiscal years.

Considerations

- NC has already demonstrated that **addressing upstream drivers of health improves Medicaid enrollees' health and reduce costs**.
  - HOP reduced Medicaid health care costs by $164 per enrollee on average and reduced ED visits and inpatient hospital admissions.
- This action aligns with similar efforts supported by North Carolina's SFY 26–27 state budget, which provides limited funding to restart HOP.
  - Accordingly, eligibility criteria and available services must be narrowed at re-launch.
  - Continued investment in HOP beyond this date would support critical access to health-related services and preserve the opportunity to reach additional populations that may benefit and could potentially bend the cost curve over time.

California: All services delivered via CalAIM's Community Supports program were associated with reduced inpatient and ED use, including nutrition services (associated with a 21.4% reduction in inpatient use and 22% reduction in ED use). A cost-effectiveness study looked at the period from six months before to six months after members received Community Supports in 2023. Most services were cost effective within the study period, with others showing early trends that they are likely to be cost-effective over a longer time.

Massachusetts: MassHealth's nutrition services program that provides nutritious food to its members was associated with a 23 percent reduction in hospitalizations and a 13 percent reduction in emergency department visits.

#10. Continue to Invest in HOP *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**High Resource Needs** *($TBD/year, based on state funding availability)*	**Likely Cost Savings**
• **Reduced** or **avoided high-cost utilization.** • **Improved health outcomes.**	• Delivery of evidence-based HOP services.	• HOP reduced Medicaid health care costs by **$164 per enrollee, per month on average,** but requires continued investment to achieve these savings.

Other Implementation Considerations	
Authority changes required	• HOP requires 1115 **waiver authority** (currently approved through 12/10/2029) and additional state share funding beyond 6/30/27.
Near term implementation timeline is feasible	• Implementation timeline for initial re-launch is **SFY 2026 – 2027.** • Additional HOP service delivery beyond 6/30/27 requires ongoing state funding.
Most stakeholders supported	• Stakeholders strongly supported this action overall, with most supporting or supporting with modifications. • Health plans asked NCDHHS to allow the services with the strongest evidence for improving cost and utilization to be offered as in lieu of services (ILOS). • Stakeholders recommended simplifying administration, integrating with existing infrastructure, continuing to evaluate outcomes and ROI, prioritizing implementation based on the strongest evidence base, and obtaining funding to support statewide access.

Action #11: Develop Maternal Health Action Plan for NC

Description

Increase statewide collaboration on maternal health to ensure a consistent and high impact approach that best uses available resources.

- Convene partners across the state actively working to address maternal and infant outcomes.
- Develop a shared vision and goals for addressing North Carolina's maternal health crisis and improving maternal and infant health outcomes that builds on existing efforts.
- Identify, assess, and coordinate actions to advance North Carolina's maternal health vision.

Consider strengthening coverage of postpartum remote blood pressure monitoring, home-monitoring prenatal visit models, and other **tech-enhanced maternal health services** for high-risk patients and to mitigate maternity care deserts.

Considerations

- **North Carolina has concerning maternal and infant health outcomes.**
  - North Carolina ranks 35th for maternal mortality and 41st for infant mortality.
  - Birth outcomes for North Carolina Medicaid births are worse compared to non-Medicaid births, with little improvement in the past five years.
  - **North Carolina also has stark disparities**: the infant mortality rate is 1.7X higher for infants with Black mothers.
- DHHS is actively working with multiple groups across North Carolina (e.g., Nurture NC, the Perinatal Quality Collaborative of North Carolina, the Perinatal Health Equity Collective) to improve maternal outcomes and **aligning efforts across all partners could help accelerate impact**.
- As a key payer of maternal care, NCDHHS could bolster work underway by mobilizing a coordinated and comprehensive statewide effort to improve maternal and infant health.
- In addition to lives saved, improved maternal outcomes can reduce costs.

California: California DHCS developed a multiyear roadmap of 42 policy actions to improve whole-person care and birth equity for Medi-Cal members from conception through 12 months postpartum, including actions related to provider access, payment, behavioral health, care coordination, and data and quality.

New Jersey: Through Nurture NJ – initially led by the Office of the NJ First Lady^ – NJ is implementing a coordinated, statewide maternal health strategy focused on bringing together state agencies, healthcare providers, and community partners to improve birth equity and strengthen care and supports.

^ The New Jersey Maternal and Infant Health Innovation Authority (established by law) is the government entity that continues the work of Nurture NJ.

#11. Develop Maternal Health Action Plan for NC

Implementation Considerations

Preliminary Expected Impact		
Increased Value Expected	**Low Resource Needs** *(<$2 million total comp/ year)*	**Cost Impact Unclear**
• **Improved** maternal **health coordination** and **outcomes** statewide.	• **Time-limited staff capacity** to convene stakeholders and **design** action plan.	• Cost savings depend on **design** of actions in the plan and **implementation.**

Other Implementation Considerations	
Authority exists already	
Near term implementation timeline is feasible	• Implementation timeline is **SFY 2028 – 2029.** • Need for stakeholder convening and design.
Most stakeholders supported	• Stakeholders strongly supported this action overall, with most supporting or supporting with modifications. • Stakeholders offered input on: specific partners to engage and ways to build on existing efforts, a need to address maternal mental health and substance use, the importance of ensuring adequate reimbursement and a robust continuum of maternity services, and a need to support rural areas.

Action #12: Strengthen Care Management Accountability & Rigor

Description

Strengthen the consistency and impact of care management to better ensure appropriate and cost-effective care.

- Develop clearer metrics to track PHP and provider performance against existing Standard Plan / AMH care management and Tailored Care Management (TCM) standards.
- Allow PHPs to hold delegated care management entities to relevant accreditation oversight processes.
- Tie PHP and provider performance to updated financial and contractual remedies, potentially including corrective action plans, PHP and provider contracting via the AMH downgrade process, and/or financial penalties (e.g., on care management fees or via sanctions/damages) for PHPs and providers that do not meet standards.

Encourage care management providers to use AI to support monitoring of patient records for care gaps (e.g., missed appointments or referrals, unfilled prescriptions), and to inform completion and refinement of care plans (AI should not be the sole input for patient-centered care plans, however).

Considerations

- Some data points to **uneven care management engagement** for Standard Plans/AMHs, despite increases in North Carolina's investment over time.
- Developing measurable standards **increases accountability and clarifies expectations**, which helps ensure care management is implemented as intended **both by PHPs and care management entities**.
- Providing PHPs more tools and creating clearer standards for accountability for both PHPs and providers could **strengthen oversight capacity and program integrity and ultimately quality outcomes (e.g., reduce avoidable inpatient utilization) and associated costs.**

California

- Health plans contract with community-based care management providers to deliver Enhanced Care Management. DHCS monitors plans, while plans monitor providers.
- DHCS monitors plans by holding recurring monitoring meetings to review performance indicators (e.g., utilization rates), issuing targeted technical assistance, tracking remediation of identified gaps, and holding follow-up meetings with lower-performing plans to explore opportunities for improvement.

#12. Strengthen Care Management Accountability & Rigor

Implementation Considerations

Preliminary Expected Impact		
Increased Value Expected	**Low Resource Needs** *(<$2 million total comp/year)*	**Cost neutral**
• **Reduced** or **avoided high-cost utilization**. • **Improved health outcomes**.	• **One-time funding** for **system updates** (e.g., modifications to existing care management dashboards). • **Ongoing staff capacity** for **design**, **implementation**, and **monitoring**.	

Other Implementation Considerations	
Authority changes required	• PHP **contract amendment** to incorporate care management accountability metrics and reflect financial and contractual remedies for non-compliance.
Near term implementation is feasible	• Implementation timeline is **SFY 2028 or 2029.^** • Need for contract amendment and system updates.
Stakeholders supported with modifications	• The majority of stakeholders supported the action as proposed or with modifications. • Stakeholders recommended extending the action to Tailored Plans (including TCM), using consistent standards and metrics across PHPs, leveraging clean and consistent data, limiting administrative and reporting burden, ensuring care managers receive appropriate training, and clearly outlining the remediation process, which would ideally include multiple escalating steps. • One stakeholder raised concerns about the impact that payment reductions could have on access to care management.

^Development of strategies to strengthen care management are already underway

III.b. Focus Area Actions & Implementation Analyses

Behavioral Health

Action #13: Expand Providers Offering Integrated Primary Care and Behavioral Health

Description

Improve the physical health of individuals with behavioral health needs by expanding integrated care models.

- Use provider incentives to increase adoption of integrated evidence-based primary care/behavioral health models for individuals with serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), and physical health comorbidities, starting with AMH+ practices. Include pediatric-specific models.
- Require Tailored Care Management (TCM) Care Management Agencies (CMAs) to provide primary care screening and monitoring that aligns with **U.S. Preventive Service Task Force Recommendations**.

Considerations

- North Carolina Medicaid enrollees with an SMI, SED, or severe SUD diagnosis represent **a disproportionate amount of spending** in the Medicaid program.
  - These enrollees represent ~27% of North Carolina's Medicaid population but ~54% of total Medicaid health spending.
  - North Carolina is in line with studies showing disproportionate spending for this population.
- Among the 10% of costliest Medicaid enrollees, those with SMI, SED, and/or severe SUD have **high hospital costs, primarily for physical health**.
  - In SFY 25, inpatient stays totaled $1.7 billion while emergency department (ED) visits totaled $310 million.
- Improved access to integrated physical and behavioral health care would help to achieve better outcomes and cost savings for this population, building on North Carolina's long-standing investments in the behavioral health continuum of care.

North Carolina (UNC Reach)

- UNC REACH implemented an enhanced primary care model for individuals with SMI and has shown **increased primary care** visits and **improved health outcomes**.
- A subsequent peer-reviewed evaluation also found **improvements in select cardiometabolic outcomes, including lower hemoglobin A1c levels and systolic blood pressure**.

#13. Expand Providers Offering Integrated Primary Care and Behavioral Health *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2–10 million total comp/year)*	**Likely Cost Savings**
• **Reduced** or **avoided** hospital **utilization** and **ED visits**. • **Improved health outcomes**.	• **Ongoing funding** to offer provider **incentives** for expansion of specialized integration models, including AMH+. • **Initial funding** to support provider **startup**, training, and implementation costs. • *If the state offered enhanced rates for providers offering an integrated model, additional ongoing funding would be required.*	• Moderate cost savings in hospitalization/ED over the medium to long-term.

Other Implementation Considerations	
Authority changes required	• TCM **provider manual updates** required to mandate CMAs to offer primary care screening. • *If the state offered an enhanced rate for providers offering an integrated model, an SPA would be required.* • Tailored Plan contract changes needed to implement provider incentives.
Near term implementation is feasible	• Implementation timeline is **SFY 2028–2029**. • Need for budget authority and policy updates.
Most stakeholders supported	• Stakeholders largely supported this recommendation, noting integrated care can improve access, coordination, whole-person care, and outcomes. • Stakeholders recommended sustainable payment, training, and implementation support, with emphasis on rural and small practices and evidence-based, pediatric-specific models. • Some stakeholders raised concerns about workforce capacity, unclear responsibilities, and administrative burden.

Action #14: Expand HCBS Supports for Individuals With Complex Co-Occurring Physical and Behavioral Health Needs

Description

Expand availability of Medicaid HCBS for people with significant physical and behavioral needs and maximize Medicaid match for these services.

- Create specialized step-down supports for individuals with SMI, severe SUD, and/or neurocognitive conditions and co-occurring physical health conditions by establishing a 1915(c)(11) home and community-based service (HCBS) waiver.

Considerations

- Beginning on July 1, 2028, states will have a new HCBS waiver option, referred to as 1915(c)(11), to **cover HCBS for individuals whose needs are less than an institutional level of care**. States can cap enrollment for this new waiver option as a way to manage costs.
- Establishing a 1915(c)(11) waiver would allow North Carolina to offer Medicaid supports to adults with complex co-occurring behavioral health and physical health needs so they can **live successfully in the community**.
  - Services could include, for example, home health aides, personal care services, in-home occupational or physical therapy, adult day health services, home-delivered meals, home modifications, non-medical transportation, respite care, transition set-up, and supported employment.
  - HCBS services are associated with decrease in the probability of a person having an inpatient discharge and ED use for at least 12 months.
- In addition to expanding access to these services, this waiver would allow North Carolina to access federal matching funds for some intensive services currently financed with state dollars, allowing existing resources to stretch further.

Colorado and Connecticut, have 1915(c) waivers for adults with SMI at a nursing facility level of care.^

Colorado expects to save $35,182 per participant through its waiver while **Connecticut expects to save $41,447 per participant** compared to what they would have spent otherwise on institutional and acute medical care.

^ A 1915(c) waiver is only available to individuals who meet an institutional level of care. A 1915(c)(11) waiver would allow for individuals with a lower level of need to access HCBS.

#14. Expand HCBS Supports for Individuals With Complex Co-Occurring Physical and Behavioral Health Needs *Implementation Considerations*

Preliminary Expected Impact

Increased Value Expected	Medium Resource Needs *($2–10 million total comp/year)*	Likely Cost Savings
• **Reduced utilization** of hospitals and SNFs. • **Improved health outcomes.**	• **Ongoing funding** to **reimburse** for new waiver **services**. • **Ongoing staff capacity** to administer the waiver. • **One-time funding** to write, submit, and gain approval for the waiver (which may be covered by federal planning dollars).	• A waiver would, at a minimum, be cost neutral compared to institutional care (as federally required), leverage federal matching funds, and over time could generate significant cost savings by diverting individuals to home- and community-based services. • It would take time to enroll people into the waiver and realize cost savings.

Other Implementation Considerations

Authority changes required	• **New 1915(c)(11) waiver** to create specialized step-down supports.^ • **North Carolina General Statute 108D amendment** to permit Tailored Plans, NC Medicaid Direct, and potentially CFSP to offer 1915(c)(11) services. • Tailored Plan, NC Medicaid Direct, and potentially Children and Families Specialty Plan **contract amendment** required to mandate plans to offer 1915(c)(11) services and comply with federal HCBS requirements. • **New CCP development** to establish requirements for 1915(c)(11) benefit.
Medium term implementation is feasible	• Implementation timeline is **SFY 2030–2031**. • Need for budget authority, stakeholder engagement, clarification of eligible populations, waiver design development and approval,^ and implementation of/readiness to provide new services (including development of appropriate workforce).
Most stakeholders supported	• Stakeholders largely supported this action, noting expanded HCBS can improve community-based care and support earlier transitions from hospitals and other higher levels of care. • Stakeholders encouraged NCDHHS to consider including Transition to Community Living (TCL) as a subpopulation or small pilot under the proposed 1915(c)(11) waiver to cover services currently supported with state funds. • Stakeholders recommended NCDHHS address existing HCBS gaps, including 1915(i) underuse, inadequate rates and capacity, and workforce and housing needs, before adding services that may not be deliverable. • Stakeholders recommended early stakeholder engagement, clear eligibility and responsibilities, sustainable funding and implementation supports, and monitoring of access, service interruptions, safety, individual choice, caregiver burden, and avoidable hospital use.

^Waiver option is not available until July 1, 2028. **Notes:** CFSP=Children and Families Specialty Plan; CCP=Clinical Coverage Policies.

Action #15: Increase Specialized Behavioral Health Nursing Facilities

Description

Increase Nursing Facility (NF) expertise in addressing complex behavioral health needs to avoid unnecessary hospitalizations.

- Increase the number of NFs (or units within NFs) that can provide short-term rehabilitative care as an alternative to hospitalization for individuals with psychiatric/ SUD/ neurocognitive conditions by enhancing reimbursement rates.
- Require mandatory training for NFs on serving individuals who have co-occurring behavioral health and physical health needs.

Considerations

- As noted earlier, North Carolina has **~$1.7 billion** in inpatient hospital costs for the costliest Medicaid members with significant behavioral health needs.
- Care in a skilled nursing facility is much less **expensive than a hospital** by bed-day.
  - North Carolina Medicaid pays ~$600/day for care in a skilled nursing facility (as of 2026) compared to ~$3000/day for care in a hospital (as of 2024).
- It is typically **difficult to place** Medicaid enrollees with complex behavioral needs in traditional settings, making expanding access important. **Traditional NFs for rehabilitation are not always equipped to address the needs of Medicaid enrollees with complex behavioral health needs**.
  - For example, over 90% of skilled NF residents with opioid use disorder go untreated.
- North Carolina Medicaid's Geropsychiatric Units in Nursing Facilities Clinical Coverage Policy already covers specialized NF services for geriatric beneficiaries with a severe and persistent mental illness. The CCP requires more intensive staffing, specialized training, and higher reimbursement rates (SPA pending), and could be expanded (and the units renamed) to include younger individuals (aged 21+) with psychiatric/SUD/neurocognitive conditions.

Connecticut

- A study of a specialized Skilled Nursing Facility (SNF) in Connecticut for individuals with SMI who were prisoners or ex-offenders showed that a tailored clinical model and a more intensive staffing ratio resulted in **a more than two-thirds decrease in acute hospitalizations in the year after admission**.

#15. Increase Specialized Behavioral Health Nursing Facilities *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2–10 million total comp/ year)*	**Likely Cost Savings**
• **Reduced** hospital **utilization** from shifting to specialized NFs (lower cost) when needed, or HCBS when individuals can be safely served in the community. • **Improved health outcomes.**	• **Ongoing funding** to pay **enhanced rate** for specialized units and for **training.** • **Time-limited staff capacity** to update policy.	• Moderate to significant cost savings over the mid- to long-term in hospital costs.

Other Implementation Considerations	
Authority changes required	• **SPA** to change the name of specialty units and the age range for the population served and increase rates. • **CCP updates** to change the name of specialty units and the age range for the population served, establish any new clinical requirements, and increase rates.
Near term implementation is feasible	• Implementation timeline is **SFY 2029–2030.** • Need for budget authority, SPA, policy updates, and coordination with HCBS implementation to support transitions across settings.
Most stakeholders supported	• Stakeholders largely supported this recommendation, noting action could address challenges transitioning medically ready patients with behavioral health needs from hospitals to appropriate care settings. • Health care facilities recommended enhanced rates for specialized staffing, training, environmental changes, and behavioral health providers, along with a survey and enforcement approach suited to this population. • Stakeholders recommended that care offered by facilities be trauma-informed, evidence-based, and non-punitive and asked NCDHHS to promote short stays, voluntary treatment, peer involvement, and discharge planning with community placement support. Stakeholders encouraged NCDHHS to pair facility expansion with expanded access to HCBS and crisis services.

III.b. Focus Area Actions & Implementation Analyses

RB-BHT

The following section outlines actions NCDHHS has already advanced to address spending and utilization trends in RB-BHT since 2025. NCDHHS is also considering further actions to strengthen the RB-BHT service.

Because this work is already underway, no implementation analysis was conducted as part of this report.

RB-BHT WORK COMPLETED TO DATE

- **August–October 2025**: Undertook a detailed assessment to identify the key drivers of spending and utilization for Medicaid RB-BHT services.
- **October 2025**: Published RB-BHT policy paper on key drivers of spending and utilization and proposed policy changes.
- **November-December 2025**: Gathered input from community partners on the findings and recommendations in the policy paper.
- **January 2026**: Established intra-departmental workgroup to develop policy changes.
- **April 2026**: Legislature passed HB 696, creating new requirements for RB-BHT delivery.
- **May-July 2026**: Posted revised CCP update for two public comment periods.
- **July 2026**: Issued provider bulletin on CCP requirements.
- **August 2026**: Promulgated new RB-BHT CCP that implemented substantial changes to the RB-BHT service.

^Action mandated by General Assembly

[ACTION TAKEN] #16: Ensure Appropriate Utilization of RB-BHT Services

Description

Ensure appropriate utilization of RB-BHT services through targeted changes to how services are authorized and updating information about covered activities.

- For treatment plans with more than 16 hours of service/week:
  - Require reauthorization of services at least every 90 days (versus 180 days for all other treatment plans).^
  - When requesting service authorization, providers must submit a typical weekly service schedule of all Medicaid-covered and non-Medicaid covered services the enrollee receives.
- Clarify in the clinical coverage policy activities that are not covered under RB-BHT (e.g., nap time, break time, respite, custodial care).

Looking Ahead: NCDHHS is reviewing options for strengthening care management requirements for individuals receiving RB-BHT. NCDHHS is also planning to strengthen RB-BHT monitoring, oversight, and compliance.

Considerations

- The RB-BHT **provider market expanded rapidly** in North Carolina over the last several years, coupled with an exponential growth in spending and utilization. Between SFY 2022–SFY 2025:
  - The number of enrollees receiving RB-BHT increased 249%.
  - RB-BHT claims increased by 305%.
  - Medicaid spending on RB-BHT spending grew by 347%.
- This action **aligns with the focus of state lawmakers and the federal government** on program integrity, oversight, and enforcement related to ABA services. CMS's ABA Toolkit cites concern with "a number of investigations leading to prosecution pointing to fraud, waste, and abuse in the ABA industry."



Virginia: Requires additional documentation for service authorization requests over 20 hours/week.



Georgia: Authorization requests exceeding 30 hours/week require an "enhanced authorization review."



Tennessee: Lists specific non-covered activities (e.g., transporting the member in lieu of parent/caregiver).

^Action mandated by General Assembly

[ACTION TAKEN] #17: Strengthen RB-BHT Treatment Planning and Standards for ASD Diagnosis

Description

Align RB-BHT service delivery with national clinical standards and current best practices.

- Require all enrollees have an individualized treatment plan, including how many hours of service they receive per week.
- Require all treatment plans be based on an assessment conducted using DHB-approved, scientifically validated tools.
- Incorporate caregivers into treatment by requiring caregiver goals in treatment plans and caregiver involvement in assessments and treatment planning.^
- Strengthen diagnosis requirements for RB-BHT eligibility, including use of DHB-approved, scientifically validated diagnostic tools.

Considerations

- The increase in RB-BHT service intensity (i.e., how many hours per week an enrollee receives) over the last several years suggests that some treatment plans were **not informed by an assessment or individualized** to the needs identified in the assessment.
  - From SFY 2022–2025, the increase in claims outpaced the increase in number of beneficiaries receiving services (305% versus 249%)
- Prior to an 8/2026 update, the RB-BHT clinical coverage policy did **not align with widely-accepted clinical standards**, including caregiver involvement to support service titration and discharge. At least one health plan reported that caregiver engagement in treatment was limited.
- North Carolina's recent RB-BHT policy actions bring the service into alignment with the bulk of the CMS's ABA Toolkit recommendations.

^Action mandated by General Assembly

[ACTION TAKEN] #18: Strengthen RB-BHT Provider Requirements

Description

Strengthen RB-BHT provider requirements and implement guardrails on use of telehealth^

- Prohibits Licensed Qualified Autism Service Providers (LQASPs) and Certified Qualified Professional (C-QPs) from enrolling in NC Medicaid as out-of-state providers (will apply to currently enrolled providers beginning summer 2027).^^
- Prohibit paraprofessionals/behavioral technicians from delivering services via telehealth.
- Require technicians providing Applied Behavior Analysis (ABA) be certified by the Behavior Analyst Certification Board or the Qualified Applied Behavior Analysis Credentialing Board.
- Establish new technician supervision minimum standards, including the maximum amount of technician supervision that may be delivered via telehealth.

Considerations

- The RB-BHT **provider market expanded rapidly** in North Carolina over the last several years.
  - The number of clinics owned by autism therapy providers grew from 61 in 2019 to 409 in 2026.
- RB-BHT providers **rely on direct observation** of behavior to make decisions regarding treatment planning and treatment delivery. Out-of-state providers who are fully remote have more limited observation opportunities.
- Requiring certification for behavior technicians promotes **standards of professional conduct**, and consistent and **high-quality service delivery**.
  - North Carolina's policy change regarding certification of technicians aligns with guidance from provider groups.

State Examples

- Thirty-seven other states plus D.C. require behavior technicians be certified.

^ Action mandated by General Assembly

^^ An LQASP develops and modifies a treatment plan and may also supervise, observe, or provide RB-BHT services. A C-QP provides and/or supervises RB-BHT services. A C-QP is a certified or provisionally licensed professional who is not licensed to practice independently.

III.b. Focus Area Actions & Implementation Analyses

Managed Care

Action #19: Simplify and Streamline Managed Care Administration

Description

Reduce administrative complexity in managed care and improve provider and member experience.

- Reduce the number of managed care plans.
- Improve **standardization** and **simplification** across plans, which could include requiring plans to:
  - Contract with State-procured vendors.
  - Follow uniform administrative processes.
  - Streamline prior authorization (PA) workflows to reduce administrative burden on providers while preserving members' access to safe, effective, and clinically appropriate treatment.

Considerations

- Although **managed care administrative spending is substantial**, with plans reporting over $1.2 billion in spending in SFY 2025, **providers and members generally report a worse experience navigating managed care** compared with FFS or commercial.
  - In the most recent survey of North Carolina primary care providers, managed care plans consistently performed worse than FFS and commercial payers on administrative domains.
  - Providers report that navigating different systems and workflows across multiple managed care plans contributes to a worse provider experience.
  - In the 2024 CAHPS report, adults in Standard Plans rated their health plan and overall health care lower than adults in North Carolina Medicaid overall.
- Providers struggling with administrative processes in Medicaid are likelier to consider exiting Medicaid.
- Streamlining prior authorization is expected to eliminate barriers to care and improve provider experience.



Ohio requires that all network provider contracts include the appropriate ODM-approved Model Medicaid Addendum; plans are directed to waive PA requirements for providers who consistently demonstrate excellence in meeting PA target metrics and coverage criteria.



West Virginia providers who have a 90% approval rate for service delivered > 30 times within six months receive PA exemptions for that service for at least six months.

#19: Simplify and Streamline Managed Care Administration *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**High Resource Needs** *($10–19 million total comp/year)*	**Likely Cost Savings**
• **Improved** provider and member **experience.** • **Reduced administrative burden** for state staff and providers.	• **Ongoing funding** to **pay** for increased capitation rates associated with some simplification strategies. • **Ongoing staff capacity** to **implement**. • Overall costs dependent on **design**, given some strategies for administrative simplification require additional PHP or state resources.	• Reducing the number of PHPs is expected to **reduce costs** by lowering the total funding needed for PHP administrative costs included in the Department's capitation payments to PHPs. • It is possible that strategies that improve access to care may impact utilization trends over time.

Other Implementation Considerations	
Authority changes required	• **Statutory amendment** to reduce the number of Standard Plans. • PHP **contract amendments** to implement simplification strategies.
Medium term implementation is feasible	• Implementation feasible by **SFY 2029–2031.** • Need for budget authority, and statutory and contract amendments.
Most stakeholders supported	• Providers supported this action, highlighting the challenge of working with a large number of managed care entities and providing additional recommendations for strategies to streamline managed care administration, such as standardizing value-based payment measures across plans. • Health plans raised concerns that reducing the number of managed care plans would impact member choice.

Action #20: Increase Standardization in Claims Processing

Description

Increase use of national standards in claims processing to improve standardization across insurance products and reduce the risk of payment errors.

- Expand use of National Correct Coding Initiative (NCCI) standards to more outpatient claims in both fee-for-service and managed care.^

Considerations

- Currently, North Carolina only applies NCCI editing to lab, radiology, and pharmacy services. Expanding NCCI editing to a broader set of outpatient procedures could provide more **consistency in claims practices across the delivery system**, including Medicare and commercial plans.
- This expansion in NCCI editing would extend the process to claims where a procedure code is required, checking that providers are submitting valid and active procedure codes.
- This policy would not change coverage policies.
- States that opt to use NCCI editing in Medicaid managed care say that doing so helps **standardize claims processing** across fee-for-service and managed care.
- From 1996 to 2013, CMS estimated that NCCI editing saved over $7.5 billion in Medicare expenditures.

In 2016, HHS OIG found that 10 states (including North Carolina) had not yet implemented NCCI edits across all the NCCI edit categories in Medicaid.

^ By requiring procedure codes required on the UB-04 guide on outpatient claims.

#20. Increase Standardization in Claims Processing *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Low Resource Needs** *(<$2 million total comp/ year)*	**Cost Impact Unclear**
• **Increased standardization** and **consistency** in claims processing.	• **Upfront funding** required for **system updates** (i.e., NCTracks). • **Time-limited staff capacity** required to **design** and **implement** internal audit workflows, **train** hospitals, providers, and health plans, and **update required** legislative **reporting**.	• Although NCCI editing can help streamline state and PHP administrative costs for utilization management and reduce improper payments, the cost savings associated with expanded use of NCCI editing in outpatient settings is unknown.

Other Implementation Considerations	
Authority changes required	• **CMS notification** may be needed to update the NCCI policy. • PHP **contract amendment** required to allow flexibility to national standards.
Near term implementation is feasible	• Implementation timeline is **SFY 2027–2028**. • Need for contract amendment, CMS notification, and systems updates.
Most stakeholders supported	• PHPs supported implementation of this proposal, indicating it would provide better alignment with Medicare and commercial payers. • Some providers raised concern, flagging the risk of increasing administrative burden for providers. They flagged the importance of transparency and provider education in implementing these changes.

Action #21: Strengthen Quality Incentives, Mechanisms for Tailored Plans

Description

Strengthen Tailored Plan quality outcomes via additional incentives and initiatives designed to strengthen quality improvement.

- Apply the Standard Plan quality, communications, and operational oversight mechanisms to Tailored Plans (on a similar implementation timeline as Standard Plans), including:
  - Convening a quality forum of the Tailored Plans to review performance on quality measures, comparable to the Standard Plan forum in its sixth year.
  - Establishing a quality withhold program, comparable to the Standard Plan program launched in 2024.

Encourage Tailored Plans to leverage tech-enabled, SUD-specific platforms (e.g., virtual prescribing, remote coaching/monitoring, wearables) to increase treatment retention and decrease overdose risk.

- These platforms may be implemented at the plan level on an opt-in basis or at the provider level (e.g., via potential quality-based financial incentives).
- This builds on evidence linking telehealth services to improved SUD outcomes.

Considerations

- North Carolina quality and cost data for people with SMI/SUD highlight the complexity of the physical health needs in the Tailored Plan population and the ensuing high costs (see slides on Behavioral Health actions for more detail).
- Improved focus on physical health care quality for these members could substantially impact outcomes and costs.
- Some research suggests **quality-based payment models can help to improve quality outcomes**.

At least 29 states are tying behavioral health measures to plan payment, including:



Two out of six measures used in **New Hampshire**'s quality withhold program are focused on behavioral health.



Two of the ten measures used in **Minnesota**'s quality withhold program are focused on behavioral health.



Managed care plans in **Colorado** can earn a lower medical-loss ratio based on performance on 3–4 quality measures, including one behavioral health measure.

#21. Strengthen Quality Incentives, Mechanisms for Tailored Plans

Preliminary Expected Impact		
Increased Value Expected	**Low Resource Needs** *(<$2 million total comp/ year)*	**Likely Cost Neutral**
• **Improved quality** and **health outcomes** for members over time.	• **Ongoing staff capacity** to **design** and **implement** withhold program.	• Cost savings will depend on the **design** of quality withhold program. • Implementation costs will likely be offset over time by **savings from long-term improvements in health outcomes**.

Other Implementation Considerations	
Authority already exists	• Authority exists, but NCDHHS has not yet exercised this authority given the maturity of the program. The Tailored Plans launched in 2024, and there is currently only one year of available quality data.
Near term implementation is feasible	• Implementation timeline is **SFY 2028–2029.** • Need to design the withhold program and hold PHP notice period.
Most stakeholders supported	• Most stakeholders supported this recommendation, emphasizing the importance of holding Tailored Plans accountable for quality and performance improvement. • Stakeholders urged the state to collaborate with PHPs, providers, and other stakeholders in designing the withhold program and recommended alignment with the Standard Plan approach.

III.b. Focus Area Actions & Implementation Analyses

Administrative & State Operations

Action #22: Enhance Qualifications and Quality Standards for Non-Clinical Providers

Description

Strengthen verification of qualifications and quality monitoring for non-clinical providers (including but not limited to RB-BHT, peer supports, mobile crisis, and HCBS direct support professionals).

- Establish/update certification and decertification requirements, building on existing certification requirements for select non-clinical provider types.
- Establish new requirements and workflows to verify and monitor ongoing qualifications, quality, and oversight for non-clinical providers that are not currently required to enroll in Medicaid (which could include a centralized enrollment pathway for these providers).

Considerations

- North Carolina's **centralized enrollment is limited to provider organizations and clinical providers**. While organizations that provide non-clinical services are enrolled, non-clinical providers employed by those organizations are not. As a result, non-clinical providers do not go through the same screening processes (e.g. background checks) as clinical providers.
- Licensure requirements used to verify clinical provider qualifications are not applicable to non-clinical providers. To help bridge that gap, North Carolina has created **certification requirements for select non-clinical providers** (including RB-BHT and peer supports).
- Data show an **elevated program integrity risk associated with non-clinical providers**.
- **Uptake and spend on non-clinical services** is substantial and increasing. For example, per-enrollee spend on peer supports increased by 130% from SFY 2021 to SFY 2025.
- NCDHHS, in partnership with the General Assembly, has already made significant progress on this action, including recent legislation to **close networks** and tighter clinical coverage policies for RB-BHT.



Oregon conducts robust training, certification, and enrollment for home care workers.



Maine has created state guidelines for mental health and rehabilitation technicians.

#22. Enhance Qualifications and Quality Standards for Non-Clinical Providers

Implementation Considerations

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2–10 million total comp/ year)*	**Cost Impact Unclear**
• **Reduced fraud, waste, and abuse** (FWA) and/or improper payments. • **Improved quality**.	• **Upfront funding** to **design** provider criteria, **system updates**, and **training** and **technical assistance** for non-clinical providers. • **Ongoing funding** to **pay** for per-provider enrollment costs, **monitor** issues, and maintain records.	• Savings from reduced FWA and improved quality are expected to reduce costs, but it is unknown whether these savings will exceed implementation costs.

Other Implementation Considerations	
Authority changes required	• **Statutory amendment** to include paraprofessionals in centralized enrollment and **North Carolina General Statute 108C-3 amendment** to add a risk assignment. • **SPA** to update provider requirements for applicable services. • Managed care plan **contract amendment** to require that plans contract only with non-clinical providers who are enrolled in Medicaid. • New **policy development** to establish requirements.
Near term implementation is feasible	• Implementation timeline is **SFY 2028–2029**.^ • Need for budget authority, statutory amendment, SPA, contract amendment, and policy development.
Stakeholders expressed mixed feedback	• Most stakeholders supported this action, noting that affected provider types should be clearly defined and cautioning against creating inappropriate barriers to entry for non-clinical providers. • PHPs supported this action and recommended implementation through expansion of the existing credentialing system.

^This assumes this action is implemented in the current enrollment system, if the state were to transition systems implementation would only be feasible in the medium term.

Action #23: Enhance Data-Driven Oversight of Utilization & Claims

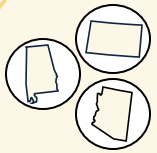
Description

Leverage technology and new resources to enhance existing program integrity functions, further reducing fraud, waste and abuse (FWA), specifically in:

- Identifying classes of providers and/or services that present an elevated risk of FWA, as well as specific higher-risk providers within those classes.
- Enhancing provider screening, coverage and prior authorization policies, claims editing, and pre-payment review in higher-risk classes.
- Leveraging analytics and post-payment reviews to identify concerning trends and verify compliance of individual providers.

Considerations

- National data indicates an **opportunity to prevent both FWA and improper payments in Medicaid**.
- **Effective program integrity policy protects enrollee wellbeing and promotes responsible stewardship of public dollars**, while avoiding undue constraints on benefit access and administrative burdens on good-faith providers.
- In recent years, advances in technology and analytics have **both created new tools for committing fraud** and provided **new tools for states and managed care plans to more effectively combat it**.
- This action would **align with similar efforts supported by North Carolina's SFY 26–27 state budget**, which provides funding for new Office of Compliance & Program Integrity (OCPI) full time equivalent (FTEs) and additional FWA detection technology for the Government Data Analytics Center.



Many states, including Arizona, Colorado, and Georgia, are leveraging CMS-certified AI platforms that analyze provider, member, claims, and financial data to monitor claiming for anomalous trends, identify high-risk providers, detect potential FWA, and track audits and recoveries.

- **Arizona** launched a first-of-its-kind AI-enabled prepayment review system, which assesses claims risk prior to payment.



D.C. has created data visualization tools (including outlier dashboards) to support program integrity staff in identifying unusual billing patterns.

#23. Enhance Data-Driven Oversight of Utilization & Claims *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2–10 million total comp/ year)*	**Likely Cost Savings**
• **Heightened prevention, detection, and recovery of improper payments, including those related to fraud, waste, and abuse**. • Reduced administrative burden for state staff.	• **Upfront funding** to establish new **system** for data-driven **monitoring**.	• Savings from prevented/recovered improper payments.

Other Implementation Considerations	
Authority changes required	• **Federal approval** to certify enhanced match for PI-related MES upgrades.
Near term implementation is feasible	• Implementation timeline is **SFY 2028–2029.** • Need to develop and implement new system and policies.
Stakeholders expressed mixed feedback	• Most stakeholders supported this action, noting that data collection should be paired with enforcement. • Stakeholders requested additional details on the methodology used to identify “higher-risk” providers and classes. • Hospitals raised concerns regarding the potential for increased provider administrative burden. One hospital raised concerns regarding the risk of collected data being used improperly by investigating agencies.

Action #24: Strengthen DHB's Risk-Based Approach to Program Integrity (PI)

Description

Strengthen DHB's risk-based PI approach by further targeting resources and oversight to the areas of greatest need:

- Repurpose eligibility-focused PI FTEs to focus on provider fraud and data analytics.
- Convert temporary roles to permanent FTEs.
- Strengthen PI requirements and reporting for managed care plans, including enhanced state oversight and potential financial sanctions for low-performing plans.

Considerations

- North Carolina Medicaid **tends to rank in the middle among other states on key PI indicators**, ranking 18th in total investigations and 29th in total recoveries as a percentage of Medicaid expenditures).
- The state has recently invested in additional resources to execute PI functions. The SFY 26–27 State Budget provides **$500,000 for up to 12 new FTEs in OCPI** and **$1.5 million for FWA detection technology** through the Government Data Analytics Center.
- Across NCDHHS, **PI resources could be better distributed** to focus on areas of highest risk and proactive policy design.
  - **NCGA designated more than half of DHB's PI team to focus on eligibility FWA**, even though the vast majority of NC's savings from PI activities have come from provider-related investigations.
  - **OCPI is seeking greater visibility into managed care plan PI activities and improved average plan performance** on PI metrics.
- Effective PI policies protect enrollee wellbeing and **promote responsible stewardship of public dollars**, while seeking to avoid undue constraints on benefit access and administrative burdens on good-faith providers.



Minnesota released a public roadmap outlining its core pillars for Medicaid PI (including training/workforce development and oversight/monitoring), which DHB may consider replicating internally.

Sources: Publicly available MFCU Enforcement Activity and Recoveries (FFY 2025); CMS-64 PI/FWA Administrative Spending (FY 2024); Myers & Stauffer, "The Case for Program Integrity in Medicaid Managed Care" (August 2025); NAMD, "Why Did They Do It That Way? Program Integrity" (June 2025); NCDHHS, Medicaid Program Integrity (April 2026)

#24. Strengthen DHB's Risk-Based Approach to Program Integrity

Implementation Considerations

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2–10 million total comp/ year)*	**Likely Cost Savings**
Increased prevention, detection, and recovery of improper payments, including those related to fraud, waste, and abuse, through strengthened workforce, health plan oversight, and internal monitoring frameworks.	• **Ongoing funding** for temporary PI staff converted to permanent FTEs.	**Savings anticipated** from prevented/recovered improper payments.

Other Implementation Considerations	
Authority changes required	• **State statutory amendment** to shift OCPI staff away from member fraud investigations to provider fraud investigations and convert temporary roles to permanent FTEs. • **Managed care plan contract amendments** related to enhanced plan oversight and to implement sanctions for low performers.
Near term implementation is feasible	• Implementation timeline is **SFY 2028–2029.**

While this action was not previewed with stakeholders before this report was published, stakeholder input is welcome via public comment on this report.

Action #25: Modernize Eligibility and Enrollment Technology

Description

Reduce manual work and support counties with improved technology:

- Make targeted improvements to NC FAST functionality, leveraging AI where possible, to reduce data entry and automate reporting.
- Simplify access to ePASS and make it easier for individuals to upload documents, report changes, and check case status (including by extending consumer experience enhancements developed for SNAP to Medicaid).
- Provide shared technology, AI enhancements, and other call center tools to counties for use in telephone intake, call recording, note-taking, and language translation.
- Develop a dedicated statewide training model and modernized policy platform/knowledge management system, leveraging AI where possible, to support county eligibility workers.

Considerations

- Applications, renewals, and consumer assistance require **substantial manual work**.
- Application and renewal processing timeframes in North Carolina generally **lag national benchmarks**.
- The **county-administered model creates variation** in staffing and operational practices across 100 DSS offices.
- **Reduction in manual work and increased automation will support**:
  - Improved application and renewal timeframes.
  - Reductions in data entry errors and omissions.
  - Improved member experience.
  - Increased bandwidth for county workers to focus on complex cases.



At least three states (Arkansas, Missouri, Oklahoma) have publicly announced plans to use AI for interacting with Medicaid consumers.

In 2023, Arizona implemented a chatbot in English and Spanish to answer to members' frequently asked questions on updating contact information, preparing for renewal, submitting documents, signing up for renewal alerts, and understanding renewal letters. Members can update their contact information using the chatbot directly.

#25. Modernize Eligibility and Enrollment Technology *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**High Resource Needs** *(>$10 million total comp/year)*	**Likely Cost Saving**
Improved timeliness, accuracy, and member experience associated with Medicaid applications and renewals.	• **Upfront and ongoing funding** to establish and maintain technology enhancements (NC FAST, enhanced ePASS, AI call center technology).	Investment in technology will be **offset by reduced county worker staff needs over time**.

Other Implementation Considerations	
Authority changes required	• **New or revised vendor contracts** for NC FAST, ePASS, and new AI tools. • Advance Planning Documents approval from CMS, if leveraging federal IT financing.
Medium term implementation is feasible	• Some changes, such as centralized training and policy platform, could be implemented in the near term (SFY 2026–2027). • Larger technology changes (e.g., changes to NC FAST) require longer timelines and could be implemented in **SFY 2029–2030.**

While this action was not previewed with stakeholders before this report was published, stakeholder input is welcome via public comment on this report.

Action #26: Address Key Workforce Gaps

Description

Fill high-priority DHB workforce gaps through additional or reallocated FTEs by:

- Identifying a limited set of open or new DHB FTEs that can be leveraged to address key gaps in DHB capacity and expertise based on a **defined set of prioritization criteria**, including but not limited to:
  - Accountability for the largest amount of spending.
  - Ability to drive operational efficiencies over time (e.g., AI strategy experts).
  - Ownership of high-risk programs (based on outcomes or level of scrutiny).
  - Critical institutional knowledge for program operations outside of contractor support.
- Reallocating existing staff to dedicated managed care oversight activities, such as financial monitoring of plan MLRs and utilization trends, oversight of plan program integrity efforts, and review of encounter data quality.

Considerations

- Addressing key gaps in expertise will enable DHB to integrate **strategic planning, data analysis, and program integrity** into decision making.
  - This could also **reduce North Carolina's reliance on contractor support**, improving DHB's institutional knowledge and reducing overall administrative costs.
- **North Carolina's managed care team is notably understaffed.** While 80% of North Carolina Medicaid is delivered through managed care, the state only has **10 FTEs** (0.4 FTEs/100K members) explicitly focused on plan administration. North Carolina has a distributed rather than centralized oversight model for managed care.

States use a variety of strategies to manage cross-functional competencies, such as finance, program integrity, and managed care plan oversight. State examples:

Program integrity (NC reference: ~60 FTEs; 2 FTEs/100K enrollees):

- **CA**: 717 FTEs (5 FTEs/100K enrollees)
- **SC**: 36.5 FTEs (3 FTEs/100K enrollees)

Considerable range across states: 1-717 FTEs

Managed care^ (NC reference: 10 FTEs; 0.4 FTEs/100K members):

- **AZ**: 150+ FTEs (10 FTEs/100K members) with centralized model
- **OH**: 50+ FTEs (2 FTEs/100K members) with distributed model

^Representing primary team

Sources: 2023 Manatt survey of state Medicaid agency managed care teams; 2026 NAMPI Conference presentation.

#26. Address Key Workforce Gaps *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Low Resource Needs** *(<$2 million total comp/year)*	**Likely Cost Neutral**
• **Strengthened agency-level capacity and institutional knowledge** in Medicaid program administration. • **Reduced reliance on contractors** for day-to-day support. • **Improved effectiveness and efficiency of managed care oversight** functions.	• **Maintenance of historical funding levels** to fill open positions and/or establish new FTEs. • Over time, funding could shift from contractor support to NCDHHS staffing.	• Investment in FTEs may be **offset by reduced reliance on contractor support**.

Other Implementation Considerations	
Authority changes required	• **Statutory approval** for limited set of new FTEs for prioritized expertise. • **Legislative support to maintain (i.e., not reduce) existing Medicaid headcount**.
Near term implementation is feasible	• Implementation timeline is **SFY 2028.**

While this action was not previewed with stakeholders before this report was published, stakeholder input is welcome via public comment on this report.

Action #27: Expand Agency-Level AI Use and Governance

Description

Accelerate AI adoption by expanding governance, resources for use cases, and workforce support:

- Enhance the current governance model, creating fast tracks for low-risk builds, identifying a clear owner of AI decisions, and keeping AI on the leadership agenda.
- Identify, investigate and prioritize use cases by picking 3–5 priority projects, scaling the staff-led build model, allocating a production budget, and performing A/B workflow testing. Example use cases include:
  - Assisting members with Medicaid applications and renewals.
  - Analyzing managed care operational reports.
  - Identifying FWA via claims/encounter data.
- Prepare the workforce and tools by offering real-world training on each team's work, protecting expert time to validate AI output and A/B test, and redesigning roles and workflows for AI.
- Leverage and manage vendors to buy specialized Medicaid tools, strengthen vendor AI oversight, and set DHB principles for working with new partners.

Considerations

- Increasing automation **would increase productivity and efficiency**.
- In 2025, DHB stood up an **AI Center of Excellence (CoE)**, which vets use cases. DHB has implemented two use cases and will soon roll out enhanced Copilot licenses.
- **DHB has not yet integrated AI into most daily operations**, partly due to a lengthy procedure for obtaining approval on a use case, lack of team bandwidth to develop specifications for use cases, limited training, and lack of funding for bigger projects.
- Business units have recently submitted requests for new FTEs **but not AI tools,** indicating a need for **workforce education on AI use cases**.

In August, Virginia Medicaid awarded a 14-year contract to **deploy AI- and automation-enabled systems solutions** including for claims processing, financial functions, reporting and call center services.

In 2024, Washington published its AI Ethics Framework with **use cases involving Medicaid data** and **guiding criteria** for AI developers, implementers, and users to protect member data.

#27. Expand Agency-Level AI Use and Governance *Implementation Considerations*

Preliminary Expected Impact		
Increased Value Expected	**Medium Resource Needs** *($2–10 million total comp/year)*	**Likely Cost Saving**
• Improved **efficiency, operations, and quality** of Medicaid administration. • Increased **program integrity and oversight**.	• **Upfront and ongoing funding** for building AI use cases, A/B testing, developing AI trainings for staff, and buying Medicaid-specific tools.	• Investment in AI will be offset by **reduced reliance on contractor support** over time.

Other Implementation Considerations	
Authority changes required	• **New procurements**/contracting for new AI products. • Potential AI-related updates to existing **vendor contracts.** • Advance Planning Documents approval from CMS, if leveraging federal IT financing.
Near term implementation is feasible	• Most recommendations could be implemented quickly, launching in the near term (**SFY 2026–2027**). • Larger AI investments, such as procurement of specialized AI tools, would require longer implementation timelines (e.g., SFY 2030+).

While this action was not previewed with stakeholders before this report was published, stakeholder input is welcome via public comment on this report.

IV. Other Opportunities Considered as Part of NC Medicaid Assessment

Overview of Other Opportunities NCDHHS is Advancing or Considered as Part of Assessment

While 27 program and policy actions were ultimately proposed through the North Carolina Medicaid Assessment, a broad set of opportunities were considered to address the findings revealed in the Landscape Analysis and the requirements of H 696.

Other Opportunities Considered as Part of Assessment

1. **Other Opportunities NCDHHS is Advancing or Plans To Advance:**
   - Medical Debt Mitigation Program
   - Beneficiaries Dually Eligible for Medicare & Medicaid ("Dual eligibles")
   - PRTF
   - HCBS Waiver Evaluation & Alignment
2. **Other H 696 Requirements Evaluated**

While these opportunities were not previewed with stakeholders before this report was published, stakeholder input is welcome via public comment on this report.

Opportunities NCDHHS is Advancing or Plans To Advance (1 of 3)

The NC Medicaid Assessment identified the following additional areas to enhance the outcomes, value, efficiency, and long-term sustainability of Medicaid, which may require additional assessment prior to implementation, or have longer implementation timelines. NCDHHS is also advancing or plans to advance work in these areas given their potential to bring value to NC Medicaid.

Area	Finding	Opportunity
Medical Debt Mitigation Program (MDMP)	• North Carolina relies on enhanced HASP payments to incentivize hospital participation in the MDMP, but that incentive will weaken as HASP payments are phased down by 10% annually, beginning in SFY 2029. • At the same time, H.R. 1-related coverage losses are expected to increase the number of patients and hospitals' uncompensated care exposure, making the MDMP's financial assistance and debt protections increasingly important. • Without a change to the incentive structure or a statutory requirement, hospital participation in MDMP is likely to erode over time, as lower HASP payments coincide with rising costs associated with MDMP participation.	• Develop long-term strategies to sustain hospital participation in the MDMP as HASP phases down, such as: ○ Other Medicaid payment levers ○ Non-Medicaid financial levers ○ State legislation to codify core MDMP consumer protections

Opportunities NCDHHS is Advancing or Plans To Advance (2 of 3)

Area	Finding	Opportunity
Dual eligibles	• In alignment with national trends, North Carolina's dual eligibles account for a disproportionate share of total Medicaid spending (~29%) compared to comprising only 15% of enrollment. • In 2025, use of high-cost institutional LTSS settings was heavily concentrated among dual eligibles age 65+, who accounted for 77% of SNF residents. • Enrollment in North Carolina's Dual Eligible Special Needs Plans (D-SNPs) among the full-benefit dual-eligible (FBDE) population surged from 7.3% in 2015 to 52% in 2023,^ mostly among adults over age 65, and is only expected to increase.	• Enhance Medicare-Medicaid integration by strengthening the effectiveness of North Carolina's State Medicaid Agency Contract (SMAC) with D-SNPs through clearer state-specific requirements around areas such as care coordination, discharge planning/transitions, information-sharing and reporting, oversight and monitoring, and benefit design. • Continue to evaluate and prioritize expansion of the PACE model.
PRTF	• Residential services, including PRTFs, are a significant source of spend for North Carolina Medicaid, totaling to over $500 million between SFY 2021–2025. • The cost of care in North Carolina PRTFs is trending upward; the average cost of a PRTF stay increased from $75,627 in SFY 2021 to $109,760 in SFY 2025. • Between SFY 2020–2024, North Carolina Medicaid youth often remained in residential treatment services for prolonged periods, with 4% of youth spending three or more years of their lives in a residential treatment setting and 7% spending two years.	• Ensure PRTFs are reserved for youth with the highest-acuity needs. • Strengthen clinical care to ensure services delivered are effective and time-limited. • Reduce re-admissions to residential treatment services overall. NCDHHS is already advancing work to improve PRTF, including a forthcoming concept paper which will inform future actions.

^ Comes from updated data in the 2024 non-published Duke Report North Carolina Medicare-Medicaid Integration: Advancing Whole-Person Care

Opportunities NCDHHS is Advancing or Plans To Advance (3 of 3)

Area	Finding	Opportunity
HCBS Waivers	• National Medicaid data demonstrates that HCBS is typically more cost-effective on an annual basis per enrollee than institutional care ($17,298 versus $54,462 per user annually). Strengthening capacity of HCBS programs is critical to NC's LTSS system rebalancing efforts, including controlling or reducing utilization and spend in more costly institutional settings. • The latest spending data and waiver waitlists for NC's four HCBS waivers indicate opportunities for improvement. In 2025, spending on inpatient hospitalizations per user of each HCBS waiver outpaced that of non-LTSS recipients. Similar trends were observed for emergency department (ED) visits, suggesting that the current array of waiver services and supports is not producing the intended health and cost-saving outcomes as designed. The Innovations Waiver currently has a waitlist of >21,000 individuals, and NCDHHS estimates the CAP/DA Waiver currently has a waitlist of 4,800 individuals. • Evaluating opportunities to realign the services provided in these HCBS programs will improve administrative efficiency, enhance and improve services and supports across programs to better meet population needs and divert more individuals away from institutional LTSS, and generate longer-term cost-savings to the Medicaid program.	• Conduct a comprehensive assessment of NC's four 1915(c) waivers to identify and implement realignment needs to increase appropriate utilization of HCBS and minimize access and outcomes disparities among HCBS enrollees. • Realignment could be to ensure the services and service levels meet participant needs, provide timely access to care and result in positive outcomes. The four-waiver structure makes sense and reflects differences in participants' needs, and the services align across the waivers to the extent it makes sense. NCDHHS is already advancing work to evaluate and align its four 1915(c) waivers.

Other H 696 Requirements Evaluated (1 of 3)

Section 3C.14 of House Bill 696 (H 696) outlined specific requirements for NC Medicaid to address in its planning. The following H 696-related actions were evaluated during this Assessment but were found to have negative impacts on health outcomes, program integrity, cost savings, and/or efficiency.

Action Considered	Key Takeaways from Assessment	Alternative Action Proposed
For inpatient hospital services and hospital laboratory services that can be provided in an outpatient setting, lower payment rates to the outpatient level such that payments are the same regardless of setting.	• Establishing equal payment rates across settings as suggested by H 696 would fail to recognize the higher clinical oversight provided in higher cost settings, such as 24-hour patient monitoring. • Some patients may need greater clinical oversight than others for the same service due to pre-existing conditions or a higher risk of complications. This policy could shift incentives too far away from inpatient settings, such that patients are not admitted to inpatient care even when clinically indicated.	• **Action 2: Make Payments Site-Neutral for Some Outpatient Services** addresses the spirit of H 696. This action would shift care to the outpatient setting while minimizing the potential disincentive to offering clinically appropriate inpatient care.

Other H 696 Requirements Evaluated (2 of 3)

Action Considered	Key Takeaways from Assessment	Alternative Action Proposed
Allow PHPs to manage utilization of GLP-1 therapies for obesity treatment by utilizing their own clinical criteria, including revising BMI criteria	While this action may decrease GLP-1 utilization by more strictly controlling who qualifies for GLP-1s for obesity treatment, allowing PHPs to modify the GLP-1 coverage for obesity treatment would: • Jeopardize the state's supplemental rebate revenue, increasing costs to the state.[1, 2] ○ A 2026 analysis by Myers & Stauffer for NCDHHS estimated that allowing PHPs to utilize their own clinical criteria for obesity treatment would increase overall costs to DHB by an estimated $227 million per year (after federal rebates). • Impact individual health outcomes, including reversing health benefits accrued during GLP-1 treatment.	• **Action 4: Connect Enrollees Prescribed GLP-1s to Supports** addresses the spirit of these H 696 requirements. This action would help to maximize the benefits of GLP-1s without jeopardizing the state's supplemental rebate revenue and could be implemented through the state's existing authority.
Allow PHPs to mandate enrollees who are prescribed GLP-1s to participate in evidence-based nutrition, weight loss, and lifestyle management programs	• This action could introduce access barriers to GLP-1s. Evidence-based nutrition, weight loss, and lifestyle management programs could help to sustain the therapeutic benefits of GLP-1s, However, evidence strongly supports that GLP-1s are effective at inducing weight loss, improving metabolic control, and reducing cardiovascular risk on their own. • Absent a state plan service on evidence-based nutrition, weight loss, and lifestyle management programs, there may not be an authority mechanism by which to require coverage of such supports. Adding a state plan service for such supports would increase state costs.	

1. The state's negotiated supplemental rebates for GLP-1s for weight loss are dependent on product placement on the state's PDL and the state's specific clinical criteria. Currently, PHPs are required to use the state-defined clinical criteria and are not allowed to be more restrictive in clinical coverage of drugs. 2. GLP-1s have other FDA-approved indications besides weight loss, which North Carolina is required to cover. Allowing PHPs to modify the clinical criteria for obesity treatment would likely result in the loss of supplemental rebates for non-obesity treatment indications in addition.

Other H 696 Requirements Evaluated (3 of 3)

Action Considered	Key Takeaways from Assessment	Alternative Action Proposed
Remove the prohibition on PHPs entering value-based arrangements that place AMH Medical Home fees and Tailored Care Management (TCM) payments at risk.	• AMH medical home fees provide stable funding for primary care practices to offer a minimum amount of direct patient care a week, provide care coordination, and arrange for emergency care for their members 24/7. Allowing AMH medical home fees to be put at risk could inhibit the ability of AMHs to offer these important primary care services. See slide 97 for more on the evidence of the value of primary care. • TCM payments fund specialized care management and whole-person supports for members with SMI/SED, SUD, I/DD and TBI, some of whom may also have high co-occurring physical health needs; the Assessment found that NC Medicaid members with SMI/SED and/or SUD accounted for a disproportionate share of inpatient and ED spending, as described on slide 53. Allowing TCM payments to be put at risk could make it difficult for organizations to continue offering TCM in local communities and could potentially increase long-term costs if physical health needs are not coordinated. • Currently, there is no prohibition on PHPs offering other value-based arrangements that include risk.	• **Action 12: Strengthen Care Management Accountability & Rigor** aligns with the spirit of this H 696 requirement. This action would ensure care management is being implemented as intended and provide PHPs more tools to strengthen oversight capacity and program integrity, including corrective action plans, PHP and provider contracting via the AMH downgrade process, and/or financial penalties (e.g., on care management fees or via sanctions/damages) for PHPs and providers that do not meet standards.

Crosswalk of Actions related to Section 3C.14 of H 696

H 696 Requirements	Proposed Actions (Section III)		Other Actions Considered (Section IV)	
	Action	Slide #	Action	Slide #
1. Reduction of DHB administrative expenses through streamlining or standardization of DHB functions.	• Strengthen DHB's Risk-Based Approach to PI • Modernize Eligibility and Enrollment Technology	129, 131	-	-
2. Increased flexibilities for prepaid health plans (PHPs), as defined in G.S. 108D-1, to manage service utilization and costs and align claims operations with national standards and best practices.	• Increase Standardization in Claims Processing	120	-	-
3. Alignment of rate schedule for inpatient hospital and hospital laboratory services that can be provided in an outpatient setting where appropriate. Where DHB determines the inpatient rate is higher than the outpatient rate, the plan required under this subsection shall include adjustment of DHB's schedule to the lower rate.	• Make Payments Site-Neutral for Some Outpatient Services	80	• For inpatient hospital services and hospital laboratory services that can be provided in an outpatient setting, lower payment rates to the outpatient level such that payments are the same regardless of setting.	142
4. Flexibilities for PHPs to manage utilization of glucagon-like peptide-1 (GLP-1) medications for weight loss, including mandatory participation in nutrition, weight loss, and lifestyle management programs. The plan required under this subsection shall not include any changes to the coverage of GLP-1 medications for diabetes, heart disease, or any indications other than weight loss.	• Connect Enrollees Prescribed GLP-1s to Supports	85	• Allow PHPs to manage utilization of GLP-1 therapies for obesity treatment by utilizing their own clinical criteria • Allow PHPs to mandate enrollees who are prescribed GLP-1s to participate in evidence-based nutrition, weight loss, and lifestyle management programs.	143
5. Improved alignment of Advanced Medical Home (AMH) and PHP contract incentives with PHP cost containment efforts through risk-sharing, value-based arrangements, and creation and appropriate oversight of quality standards for delegated care management entities. The plan required under this subsection shall include the removal of any prohibitions on PHPs from entering contracts with AMHs in which AMH and care management fees are at risk in value-based arrangements.	• Strengthen Care Management Accountability & Rigor	103	• Remove the prohibition on PHPs entering value-based arrangements that place AMH Medical Home fees and Tailored Care Management (TCM) payments at risk.	144
6. Improved reporting on AMH care management activities including staffing, populations receiving different levels of care management, any measurable outcomes at each level of care management, and recommended legislative changes.	• Strengthen Care Management Accountability & Rigor	103	-	-
7. Improved network management provider credentialing and certification tools for nonclinical providers to ensure qualified providers are delivering services and to expedite removal of non-qualified providers.	• Enhance Qualifications and Quality Standards for Non-Clinical Providers	125	-	-

Source: H 696 Ratified Bill; **Note:** the RB-BHT actions relate to Section 3C.18 of H 696 so are not included in this table.

V. Conclusion

Key Takeaways



A **strong and sustainable Medicaid program** is **critical to** the health and prosperity of **North Carolinians**.



NCDHHS is committed to working with the North Carolina General Assembly and stakeholders to prioritize these actions and **advance targeted changes** that **maximize the value, outcomes and/or efficiency of North Carolina Medicaid**.



Recommendations for additional actions and **feedback** on this report can be provided through public comment. - through December 21, 2026

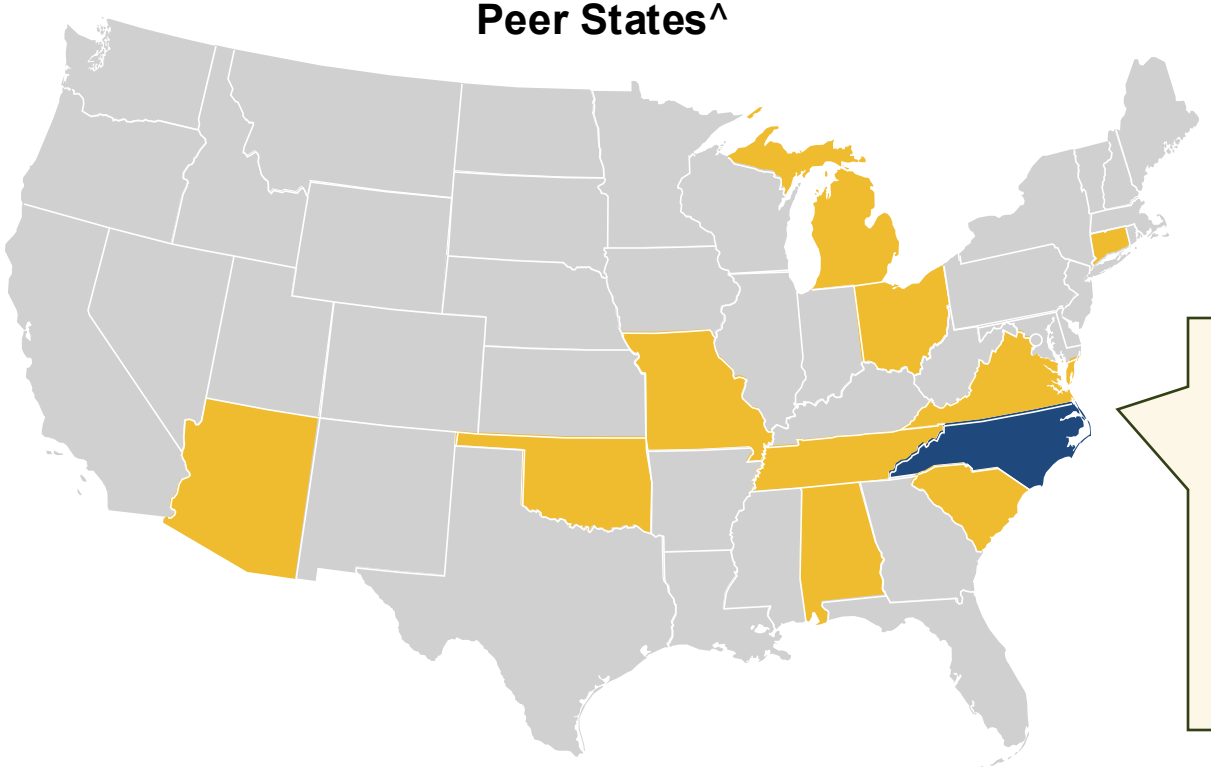
Appendix:
II. Landscape Analysis Approach and Findings

Appendix: Landscape Analysis Approach

Landscape Analysis Peer States

North Carolina Medicaid leadership identified a cohort of Peer States including states with both like and unlike delivery systems and program models.

Peer States^



Note: Alternative Peer States used for analyses within some focus areas (e.g., LTSS).

	Primarily Managed Care^^	Medicaid Expansion^^^	
North Carolina	✓	✓	*12/2023*
Alabama	☒	☒	
Arizona	✓	✓	*01/2014*
Connecticut	☒	✓	*01/2014*
Georgia	✓	☒	
Michigan	✓	✓	*04/2014*
Missouri	✓	✓	*07/2021*
Ohio	✓	✓	*01/2014*
Oklahoma^	✓	✓	*07/2021*
Tennessee	✓	☒	
Virginia	✓	✓	*01/2019*

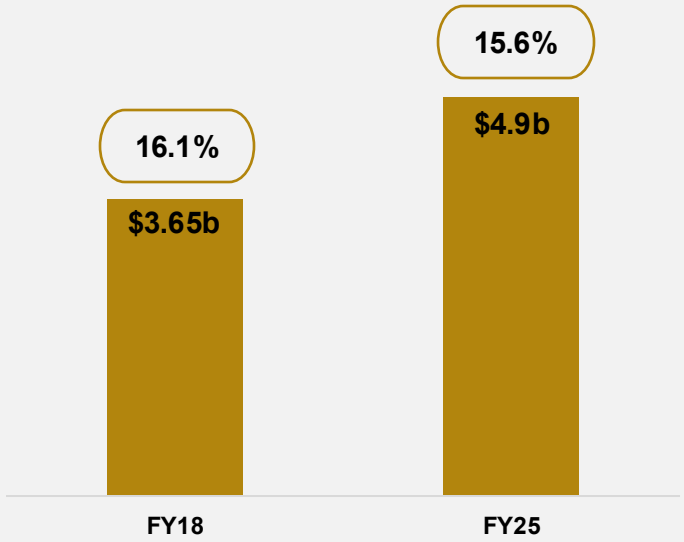
Notes: Peer States were identified and confirmed by NCDHHS. (1) Refers to states with >50% of population in managed care. ^Oklahoma transitioned from an FFS delivery system to managed care effective April 1, 2024.

Source(s): ^^KFF, Total Medicaid MCO Enrollment; ^^^KFF, Status of State Medicaid Expansion Decisions.

Legislative Appropriations vs. NASBO Reporting: Key Differences

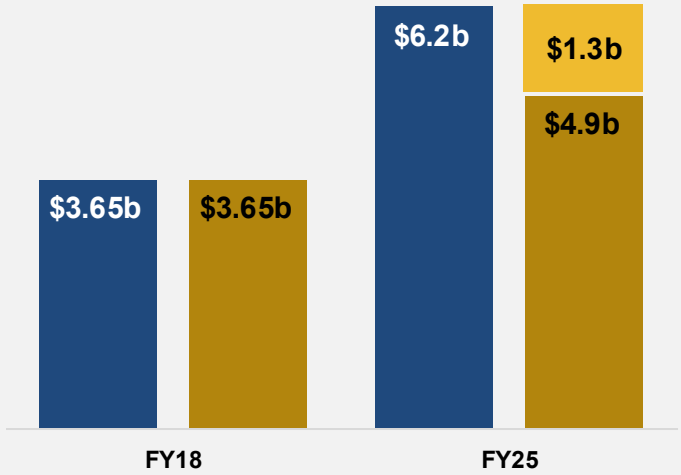
Legislative appropriations (NC DHB)
General fund expenditures (NASBO)
Other contributions (NC DHB)

1. NASBO presents share of spending, not dollars



NASBO-reported Medicaid spending grew a third. Total General Fund spending grew about as fast, so the share held near 16%.

2. NASBO does not account for non-general fund contributions



Same number in FY18. By FY25, legislative appropriations were $1.3b more than NASBO-reported spending: 19.7% vs. 15.6% of the same spending.

3. Reduced federal contributions after FY25 contribute to higher state legislative appropriation requests

On the NASBO chart

FY18 to FY25

After the chart

FY26
+$319m

FY27
+$1.08b

The last temporary federal match bump ended 9/30/25. The FY26 and FY27 increases come after the chart's last year.

Source: NCDHHS, DHB | DHB Annual Report Table 4 (budget); NASBO State Expenditure Reports, 2020, 2022 and 2025 editions. Shares use General Fund spending as reported to NASBO.

Framework for Assessing NC Medicaid Quality and Outcomes

The project used available measures across clinical areas, populations, and three measure types to provide a broad view of NC Medicaid quality and outcomes.

Three Measure Types:

1) Process Measures	2) Outcomes Measures	3) Utilization Measures
Whether recommended care was delivered (e.g., well-child visits, metabolic monitoring, follow-up after hospitalization).	**Whether an enrollee's health status changed** (e.g., A1c control, blood pressure control).	**An enrollee's use of health care services** (e.g., hospital admissions, readmissions, ED visits).

SIX CORE SET DOMAINS

Included in this report^

- Behavioral health care
- Care of acute and chronic conditions
- Primary care access and preventive care
- Dental and oral health services
- Maternal and perinatal health
- Experience of care

Notes: "Outcome averages" is used as an umbrella term for the clinical process, clinical outcome, and utilization measures reviewed. Not all measures are outcomes as formally defined in quality measurement. North Carolina's recent policy shifts (e.g., Standard Plan launch in 2021 and Tailored Plan launch in 2024) are not fully reflected in the data years available. A single all-state average provides a more stable and consistent benchmark.

Focus Area Analysis Approach

Data provided by Marsh and the Quality, Population Health, and Evaluation unit were supplemented with publicly available data to support Focus Area and Outcomes analyses.

Approach

- Analyses examining spending by Focus Area relied heavily on historical "Universal Base Data Summaries" (UBDS) provided by Marsh, which capture FFS and managed care spending by service category.
- Universal Base Data Summaries were used to:
  - Calculate spending associated with detailed service categories to assess North Carolina's largest internal cost centers and cost drivers.
  - Benchmark North Carolina's LTSS, hospital, and NEMT spending trends relative to Peer States.
- Publicly available data were used to benchmark North Carolina's prescription drug and administrative spending trends relative to Peer States.
  - Publicly available data were also used to compare outcomes and utilization by state across focus areas, where possible.
- Outcomes analyses used CMS Medicaid and CHIP Core Set quality measures and data from QPHE and benchmarked North Carolina against the national average and Peer States.

Note: *Additional details on data sources used for Focus Area and Outcomes analyses and construction of service categories from Universal Base Data Summary Reports are available in the Appendix.*

Data Sources for Cross State Focus Area Analyses

Data Sources Used to Support Analyses on Spending		
Focus Area	**NC Data Source**	**Peer State Data Source**
LTSS	UBDS	CMS-64 Reports
NEMT		
Behavioral Health	N/A	
Hospital Services	UBDS, CMS SDP Preprints, CMS-64 Reports	CMS-64 Reports
Primary Care and Population Health	Milbank Primary Care Scorecard	
Prescription Drugs	CMS State Drug Utilization Data	
Administrative Services	CMS-64 Reports	

Data Sources Used to Support Analyses on Utilization and Outcomes	
Focus Area	**Data Source** *(For Both NC and Peer States)*
LTSS	LTSS Users and Expenditures Report; AARP LTSS Scorecard
NEMT	N/A
Behavioral Health	Adult and Child Core Set Quality Measures
Hospital Services	HCRIS
Primary Care and Population Health	Adult and Child Core Set Quality Measures
Prescription Drugs	CMS State Drug Utilization Data
Administrative Services	N/A

Data and Reporting Limitations

This Analysis relies on publicly available data to support cross-state comparisons. While public data offer standardized methods to support such comparisons, they also have notable limitations.

Key Limitations

- **Data Timeliness**: Public data for metrics-of-interest may be several years lagged, limiting timely comparisons.
  - *Mitigation Strategy*: critical trends will be confirmed with more recent North Carolina data, where data are available.
- **Data Availability**: Public data are not always available for all service categories and populations.
  - *Mitigation Strategy*: North Carolina-specific data and gray/academic literature will be used to fill critical information gaps, where possible.
- **Data Comprehensiveness**: Public data do not necessarily reflect individual state environments, including differences across populations, delivery systems, policies, and programs.
  - *Mitigation Strategy*: quantitative analyses will be supplemented with targeted qualitative analyses comparing environmental and program differences across states.
- **Anomalous Trends**: While the COVID-19 Public Health Emergency (PHE) in 2020–2022 impacted enrollee behavior and Medicaid health care financing in all states, the magnitude of the impact differed considerably across states, confounding exact comparisons. Additionally, North Carolina's recent implementation of Medicaid expansion and managed care differentiate it from other states, complicating cross-state comparisons.
  - *Mitigation Strategy*: data baseline years extended back to 2018 to isolate COVID-19 related impacts; per member metrics were used, where data was available, to normalize increase in enrollment and spending in North Carolina during latter years of assessment period.

Key Data Limitations & Mitigation Strategies

Publicly available data offer standardized cross-state comparisons but have notable limitations.

Data Limitation	Overview	Mitigation Strategy
Managed Care Spending	Data often do not disaggregate managed care spending by service category.	• Used data provided by Marsh to assess North Carolina spending by service category and used FFS states to benchmark spending by service category. • Identified alternative sources related to focus areas of interest.
Timeliness & Granularity	Data often lag by several years and may be higher level than desired.	• Leveraged TAF to fill in critical data gaps. • Used the most recent and detailed public data available.
Policy Context	Data do not reflect individual state policy and operational environments.	• Supplemented quantitative analyses with targeted qualitative analyses comparing environmental and program differences across states.
Data Availability & Reporting	Core Set data are missing or limited for several measures. Supplemental QPHE data are NC-specific.	• Supplemented Core Set measures with QPHE data where available. • Limited peer comparisons to measures with Core Set data.
Changing Populations	Medicaid expansion (December 2023) and the addition of duals (2024) changed who is measured.	• Compared first and most recent years rather than focusing on 2023–2024. • All rates are averages of state-reported rates across all Medicaid and CHIP populations unless otherwise specified.
LTSS Benchmarks	No national benchmarks are available for MLTSS measures until states report in 2026 to 2028.	• Used the AARP LTSS Scorecard for national context.

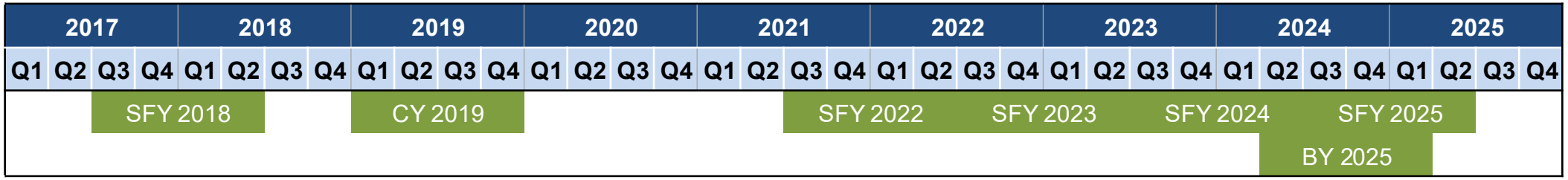
Limitations of Universal Base Data Summaries

While detailed, Universal Base Data Summaries (UBDS) provided by Marsh are subject to several notable limitations.

Key Limitations

- **Missing Time Periods**: These reports were not consistently produced during the COVID-19 Public Health Emergency, leaving several years of missing data (*see timeline below*).
- **Varying Time Frames Captured**: Reports vary in whether they are based on CYs, SFYs, or Business Years (BYs) defined by Marsh, while CMS-64 data used to support cross-state benchmarking are based on FFYs.
- **Missing Data**: Reports do not capture data on state administrative spending or hospital supplemental payments.
  - Data on FFS hospital supplemental payments and state administrative spending were gathered from CMS-64 Reports.
  - Data on hospital directed payments subject to separate payment terms were gleaned from CMS preprints.

Time Periods Covered by UBDS Reports



Appendix: Focus Area Findings

Appendix: Focus Area Findings

Hospital Services

NC's Hospital Payment Strategy Has Changed Significantly in Past Five Years

Since 2021, North Carolina has made major changes to hospital payments to improve healthcare coverage and access to services and reduce medical debt. Gains may be at risk due to H.R. 1.

Jul 2021: Transition to Managed Care

NC incorporated hospitals' historical supplemental payments into base rates and/or state-directed payments (SDPs), tying payment levels more directly to utilization. In parallel, the state restructured the hospital assessment.

Jul 2024: MDMP Launch

Starting in SFY 2025, NC tied HASP payment levels to hospitals' participation in the state's groundbreaking Medical Debt Mitigation Program (MDMP), resulting in >$6B in medical debt forgiveness in year 1.



Dec 2023: Medicaid Expansion + HASP

To fund Medicaid Expansion, NC created a second hospital assessment and increased hospital payment levels through the Healthcare Access and Stabilization Program (HASP) SDP.

Jul 2025: H.R. 1 Enacted

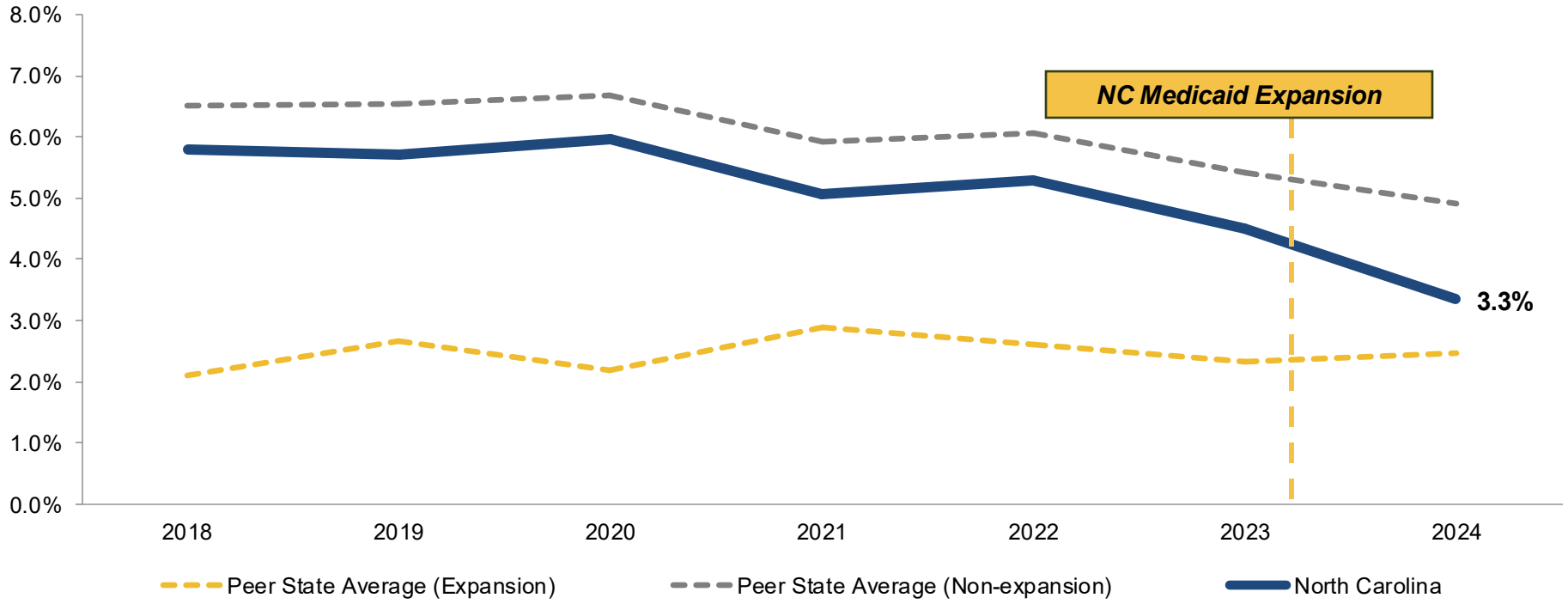
H.R. 1 reduces the maximum allowable levels of SDPs and provider taxes. This will result in cuts to hospital payments and puts NC's Medicaid Expansion financing strategy at risk.

Please note: Given recency of some hospital payment strategy changes, the full impact may not yet be captured in quantitative data.

Early Findings Show Expansion Is Reducing Hospital's Uncompensated Care

Uncompensated care at North Carolina hospitals fell to 3.3% of net patient revenue in 2024 after Medicaid expansion, closing much of the gap with Peer Expansion States in just one year.

Uncompensated Care as a Share of Net Patient Revenue, FFY 2020 – 2024



Key Findings

- **Medicaid expansion has already reduced hospital uncompensated care** as residents gain coverage — and since this data captures only expansion's first year, **further declines are likely**.
- **However, these gains are likely to be offset** by future coverage losses – Medicaid losses under H.R. 1 and Marketplace losses from the termination of enhanced premium tax credits.

Notes: North Carolina expanded Medicaid in December 2023. This percentage is calculated as the cost of uncompensated care, including net charity care cost and net and net bad debt cost, divided by net patient revenue. Data reflects the state in which the hospital is located, which may not always be the state Medicaid agency paying for an enrollee's care. Peer state averages are unweighted. CY = Calendar Year.

Source: Uncompensated care amounts were calculated using the 2024 NASHP Hospital Cost Tool.

Investment in HASP and Medicaid Expansion Came at No State Cost

North Carolina General Statute requires that HASP and Medicaid expansion be funded by revenue sources outside the State General Fund – primarily hospital assessments and IGTs.

HASP Statute

§ 108A-148.1. Healthcare access and stabilization program.

…

(c) All State funds required to make HASP directed payments shall be derived from HASP components of the hospital assessments under this Article, subject to all of the following limitations:

(1) If the Department determines that the HASP components under this Article will not generate funds in an amount equal to or greater than the total State funds required to make all HASP directed payments in any given quarter of the State fiscal year, then the Department shall reduce the amount of the HASP directed payments in the lowest amount necessary to ensure that the HASP components under this Article will generate enough funds to equal the total State funds required to make all the HASP directed payments in that quarter.

(2) If the aggregate amount of all assessments due from hospitals under this Article are determined by the Department to exceed the permissible limit established under 42 C.F.R. § 433.68(f) in any quarter of the State fiscal year, then the Department shall reduce the amount of the HASP directed payments in the lowest amount necessary to ensure that these hospital assessments in aggregate do not exceed the permissible limit.

Medicaid Expansion Statute

§ 108A-54.3B. Nonfederal share of NC Health Works costs.

(a) As used in this section, the following definitions apply:

(1) Cost. – All expenses incurred by the State and counties that are eligible for Medicaid federal financial participation.

(2) NC Health Works. – The provision of Medicaid coverage to the individuals described in G.S. 108A-54.3A(a)(24).

(b) It is the intent of the General Assembly to fully fund the nonfederal share of the cost of NC Health Works through a combination of the following sources:

(1) Increases in revenue from the gross premiums tax under G.S. 105-228.5 due to NC Health Works.

(2) Excluding any State retention, the increases in intergovernmental transfers due to NC Health Works.

(3) Excluding any State retention, the hospital health advancement assessments under Part 3 of Article 7B of Chapter 108A of the General Statutes.

(4) Savings to the State attributable to NC Health Works that correspond to State General Fund budget reductions to other State programs.

Appendix: Focus Area Findings

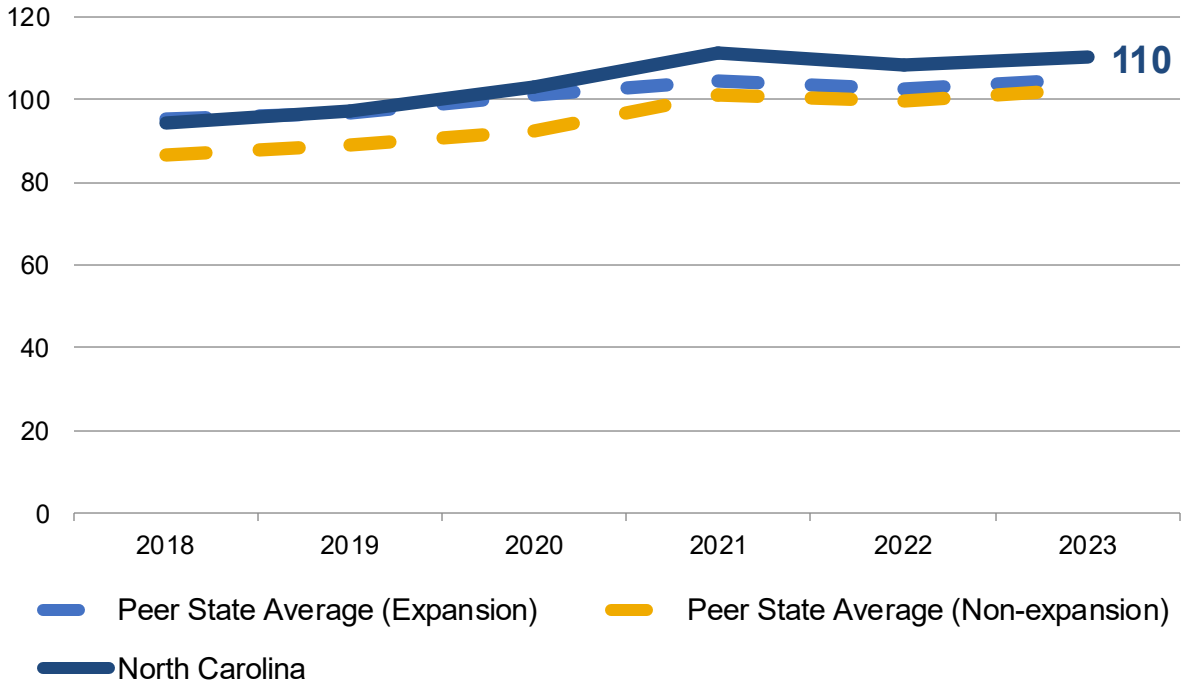
Primary Care and Population Health

North Carolina Leads Peer States on Supply of Primary Care Physicians

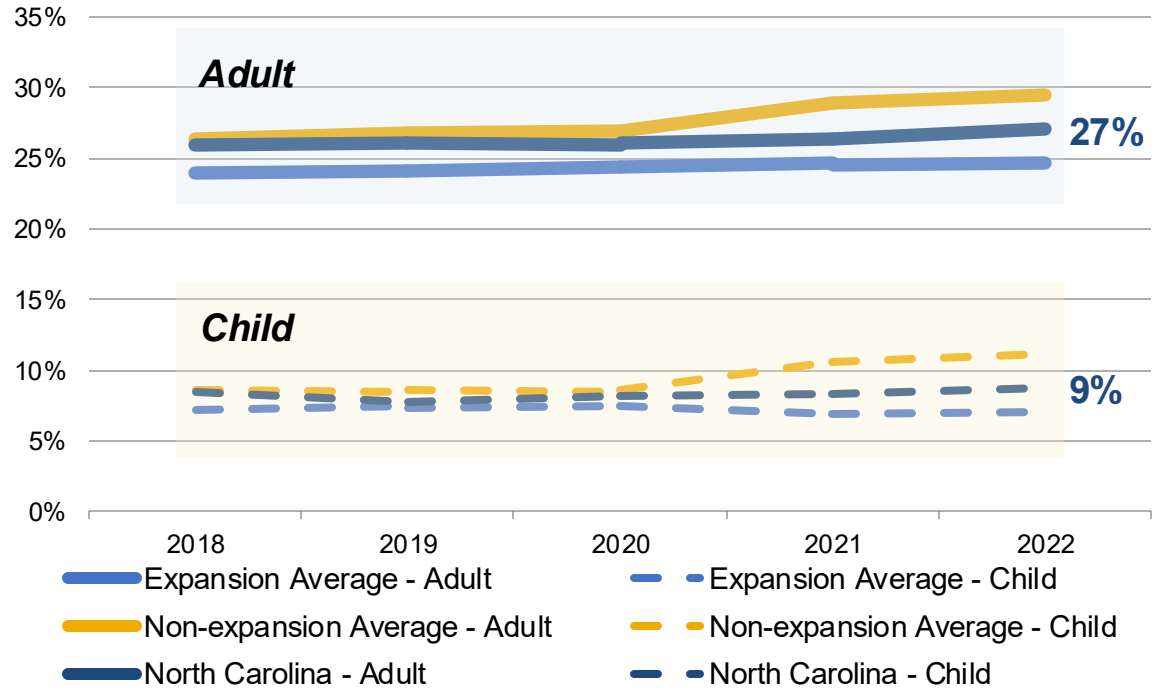
North Carolina's primary care clinician supply exceeds the peer state average, while access to a usual source of care remains broadly in line with peer states.

Number of All Primary Care Clinicians per 100,000 Population, CY 2018 to CY 2023

Time periods do not reflect NC Medicaid expansion



Percentage of Population without a Usual Source of Care, CY 2018 to CY 2022

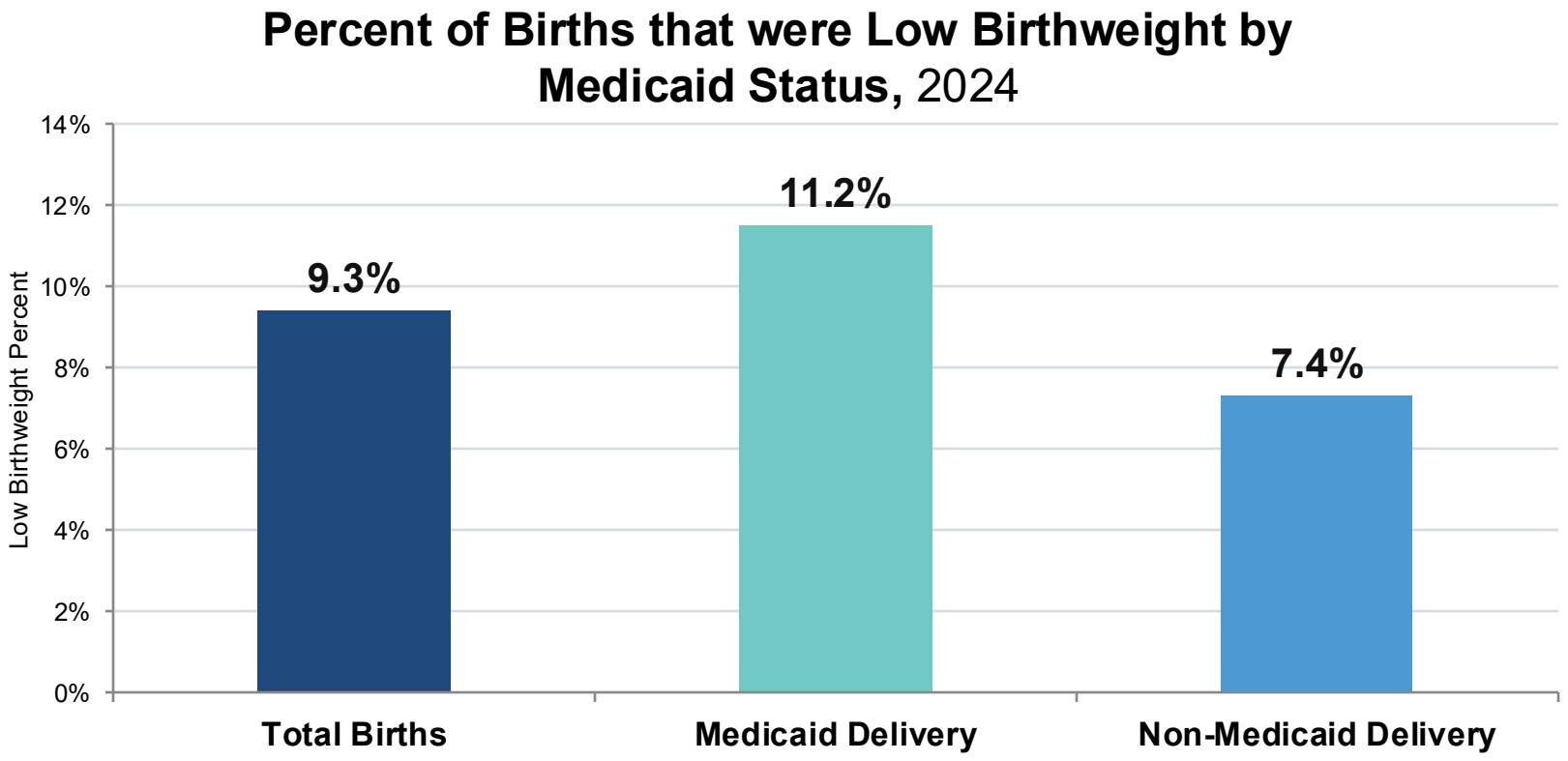


Notes: All Primary Care Clinicians includes primary care physicians, nurse practitioners, and physician assistants identified usinga combination of provider databases. Usual source of care excludes the emergency department as a source of care. Peer state averages are unweighted. CY = Calendar Year.

Source: Milbank Primary Care Scorecard analysis of AMA Masterfile, CMS PECOS, and NPPES provider databases and analysis of MEPS.

North Carolina Trails Other States on Maternal and Infant Health Outcomes

Births covered by Medicaid were more likely to be low birthweight than non-Medicaid births in 2024.



Key Considerations

- Lower is better for this measure.
- North Carolina ranks 35th for maternal mortality and 41st for infant mortality, while the infant mortality rate for babies born to Black mothers is 1.7 times the statewide rate.
- Multiple groups are actively working with multiple groups to improve maternal outcomes in North Carolina (e.g., NC Nurture, the Perinatal Quality Collaborative of North Carolina).

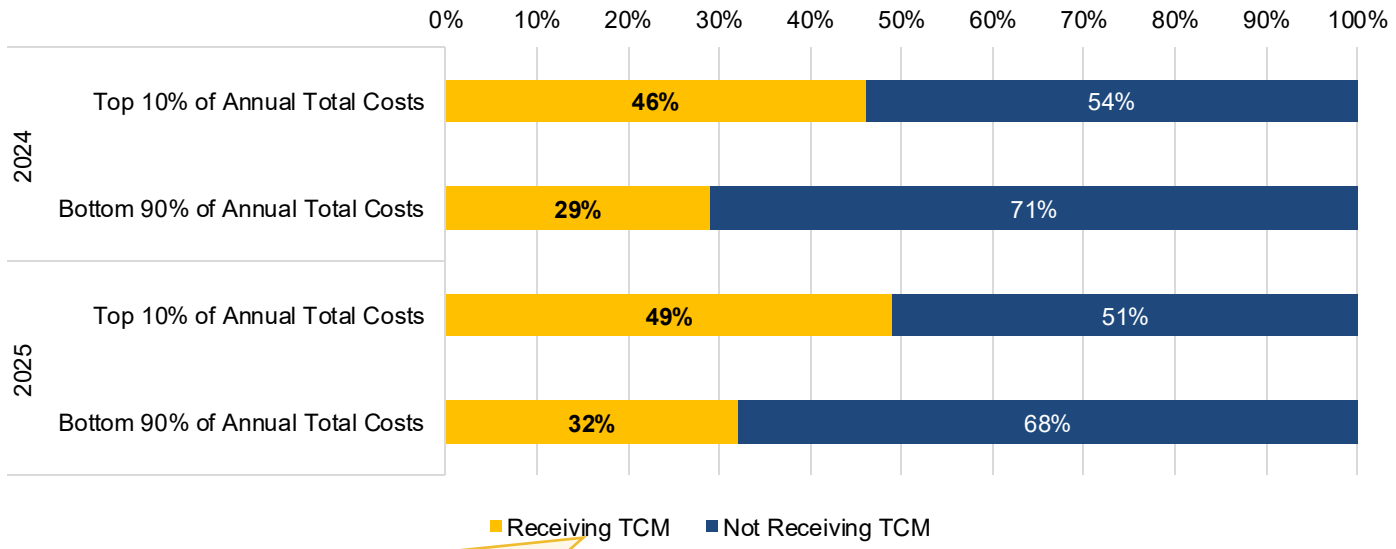
Notes: Low birthweight is defined as birthweight below 2,500 grams. Medicaid status reflects the delivery payer classification in linked North Carolina resident live birth certificate and Medicaid claims data. Percentages reflect 2024 births, the latest available linked Medicaid birth data.

Source(s): March of Dimes, 2025 March of Dimes Report Card for North Carolina; NCDHHS Division of Public Health, N.C. Maternal and Infant Health Data Dashboard.

Tailored Care Management Is Reaching High-Cost Individuals

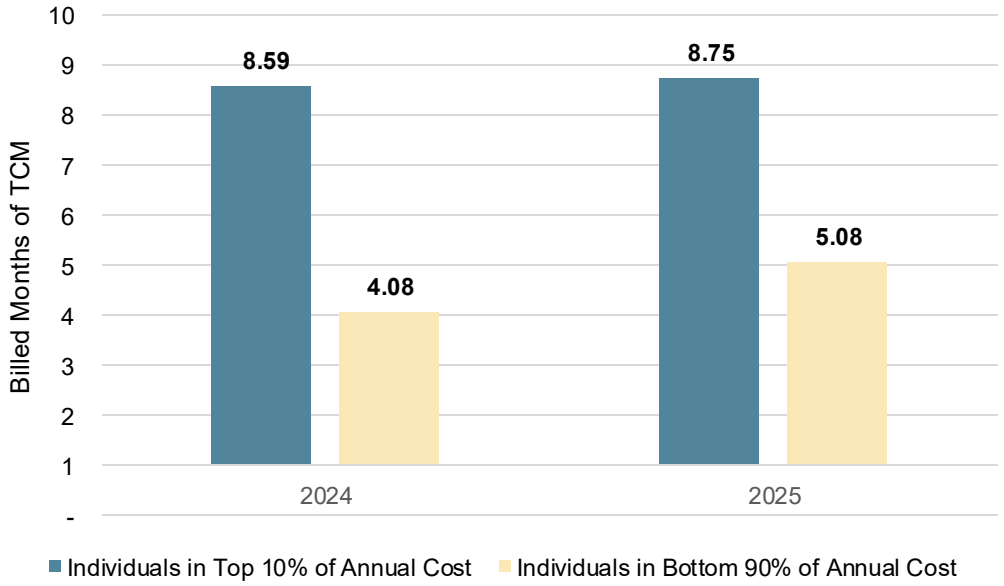
High-cost individuals are more likely to engage in Tailored Care Management and are engaged for more months throughout the year.

Tailored Care Management Engagement Among Eligible Individuals in the Top 10% and Bottom 90% of Total Annual Costs



Engagement increased slightly from SFY 2024 to 2025 across the eligible population, with engagement being higher for people who represent the top 10% of total annual costs.

Average Billed Months of Tailored Care Management per Year, Among Those Engaged



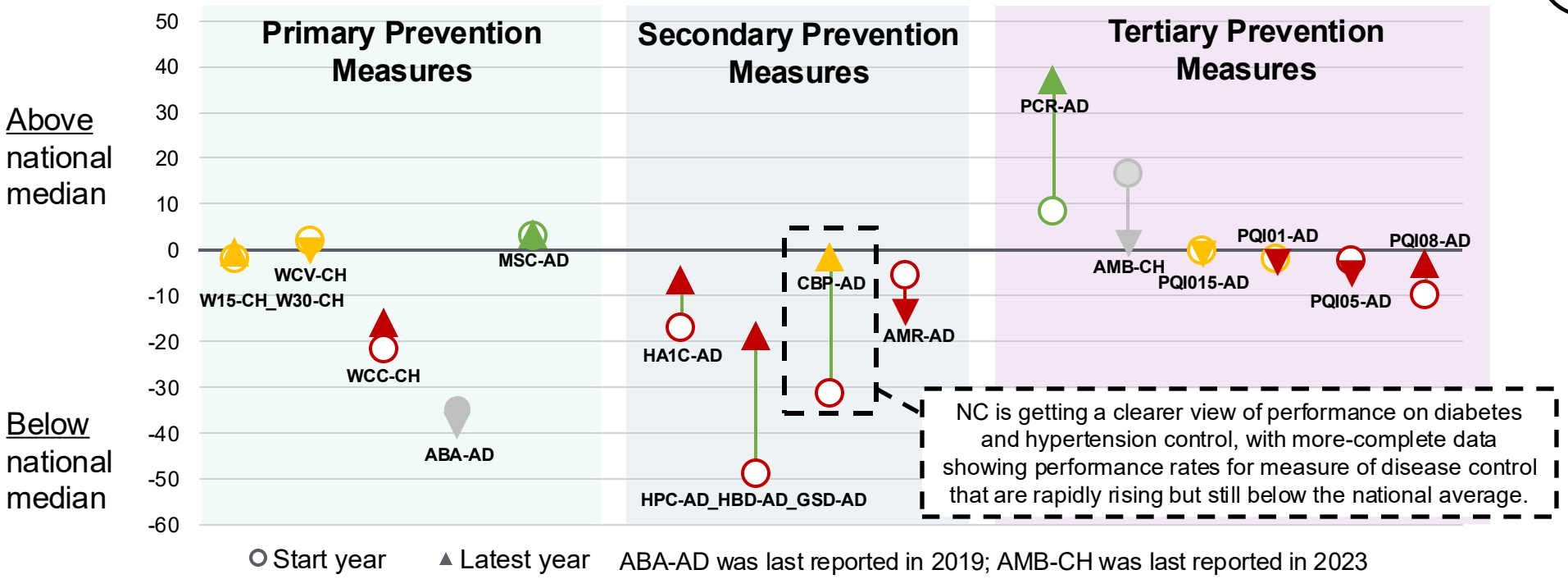
On average, high-cost, engaged enrollees received more annual months of Tailored Care Management (8.75), when compared to lower-cost beneficiaries (5.08).

Source: Analysis of Marsh-provided data.

NC Chronic Disease Performance Improving In Some Areas

Since 2017, North Carolina has improved against the national average on eight chronic disease measures, though rates for most remained at or below national medians in 2024.

North Carolina Chronic Disease Performance Relative to National Median by Prevention Level, Most Recent Year Available



North Carolina Medicaid Data Quality Improvements

DHB has invested heavily in improving data quality and reporting in recent years, with notable improvements in accuracy and completeness. This has allowed North Carolina to better capture care being delivered in key areas, including diabetes, hypertension, and prenatal care.

Notes: Data points are color-coded by the percentage point difference between North Carolina and the national median for a measure (green: > 2 points above; yellow: within 2 points; red: > 2 points below). Results for measures where a lower level is better were adjusted so that the direction of improvement is the same across measures. CBP-AD results should be interpreted with caution due to known data quality issues. Core Set reporting year data generally correspond to services provided in the prior calendar year (e.g., 2024 Core Set data reflect CY 2023 services). MSC-AD reflects a single year of data (CY 2024), so no change over time is shown. CY = Calendar Year. "Most recent year available" reflects differences in measure reporting and availability; the latest year shown varies across measures. For diabetes measures, rates of poor control (>9/0%) were combined across multiple measures to allow a longitudinal view of performance.

Source: Medicaid and CHIP Adult and Child Core Set Quality Measures.

Above National Median / Improving | About the same | Below National Median / Declining

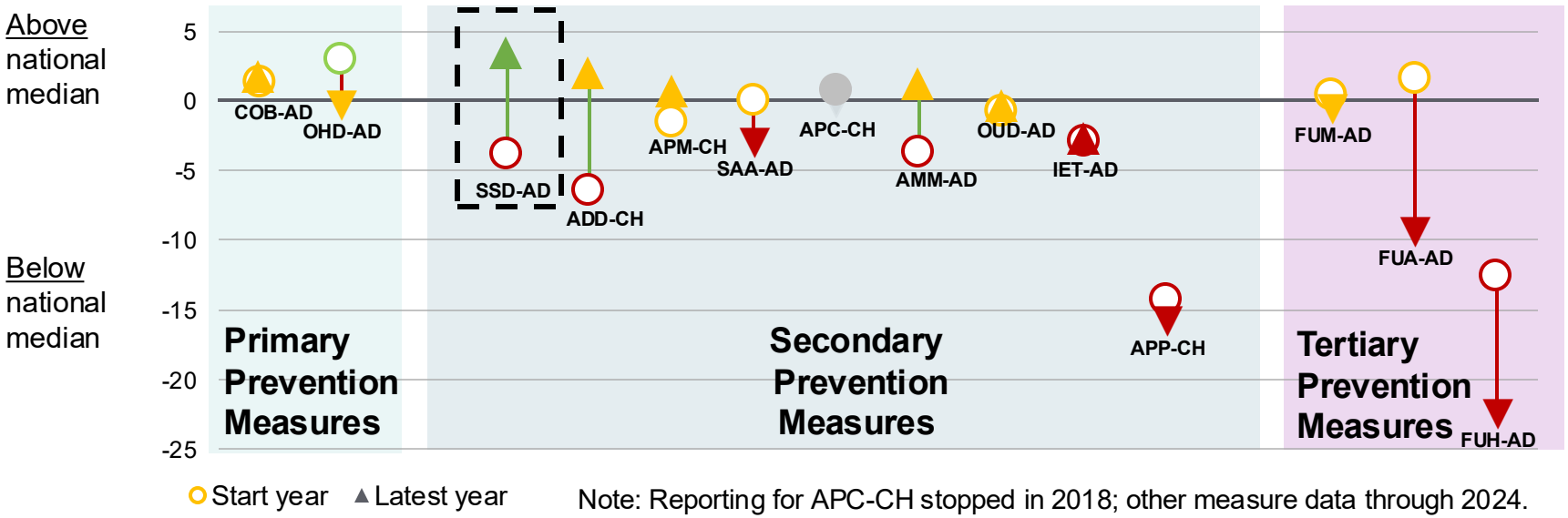
Appendix: Focus Area Findings

Behavioral Health

NC Performance on Measures of Behavioral Health Is Variable

North Carolina's performance on behavioral measures has varied over time, with most measures falling at or below national and peer state medians as of 2024.

North Carolina Behavioral Health Performance Relative to National Average by Prevention Level, Most Recent Year Available



Note: Reporting for APC-CH stopped in 2018; other measure data through 2024.

Program Context

- **Integration of Physical and Behavioral Health Care** performance, as indicated by diabetes screening for people with diabetes and schizophrenia or bipolar disorder (SSD-AD), has been at or above the national median since 2020.
- Where stratified data are available, including for follow-up after ED visits and hospitalizations, TPs have outperformed SPs on behavioral health measures.

Emerging Assessment Area: North Carolina's ability to assess its investments in behavioral health is still developing. Key programs such as Tailored Plans only have one full year of performance data, limiting the state's ability to observe impacts or benchmark over time. Further, several important behavioral measures, including measures of follow up after hospitalization and ED visits, have undergone substantial specification changes, limiting ability to trend results and assess progress over time.

Notes: Data points are color-coded by the percentage point difference between North Carolina and the national median for a measure (green: > 2 points above; yellow: within 2 points; red: > 2 points below). Results for measures where a lower level is better were adjusted so that the direction of improvement is the same across measures. CY = Calendar Year. "Most recent year available" reflects differences in measure reporting and availability; the latest year shown varies across measures.

Source: Medicaid and CHIP Adult and Child Core Set Quality Measures.

Above National Median / Improving | About the same | Below National Median / Declining

NC Has Made Significant Investments In Behavioral Health Access & Quality

North Carolina made significant investments to expand access to and quality of Medicaid-funded behavioral health services in 2022 and 2023, including support for the direct care workforce, launching Tailored Care Management, and expanding eligibility for home and community-based services (HCBS).

Jun. 2017: NC Releases Opioid Action Plan (OAP)

- NC developed OAP with community partners to combat the opioid crisis.

Dec. 2022: Tailored Care Management launches

- NC introduces new model where multidisciplinary care teams provide whole-person care management to help people with serious mental illness, severe substance use disorder (SUD), intellectual/developmental disabilities (I/DD), or traumatic brain injury (TBI).

Jul. 2023: Establishment of 1915(i) HCBS in the State Plan

- In July 2023, NC transitioned certain HCBS from 1915(b)(3) authority to 1915(i) via a state plan amendment. This transition expanded the populations eligible for HCBS and allowed HCBS to be offered for Tailored Plan enrollees after launch.
- Payment rates were explicitly maintained.

2022 | 2023

Mar. 2022: ARPA-funded HCBS Direct Care Worker Rate Increases Take Effect

- North Carolina General Assembly increased legislative funding to allow NC to sustain wage increases for direct care workers following the end of pandemic-era federal funding.

Oct. 2023: NCGA Made an Historic $835M Investment for Behavioral Health

- Increased reimbursement rates for behavioral health providers (Effective 01/2024).
- Support for the Children and Families Specialty Plan (CFSP) launch.
- Investments to expand access to treatments and programs for children with complex needs, including North Carolina Psychiatry Access Line (NC-PAL), funding for residential treatment services, and Collaborative Care model to promote integrated care.
- Funding for the crisis system, including the expansion of mobile crisis teams.
- Expansion of the re-entry, diversion, and capacity restoration programs.

Notes: Services Included: Supported Employment/Individual Placement Supports; Community Living and Supports; Individual and Transitional Supports; Respite; Community Transition.

NC Has Made Significant Investments In Behavioral Health Access & Quality

With the launch of the Tailored Plans and CFSP in 2024 and 2025, North Carolina continued its transition to managed care and furthered its support for the specialized behavioral health needs of North Carolinians.

Jul. 2024: Tailored Plans Launch

- In July 2024, NC launched Tailored Plans for people with serious mental illness, serious emotional disturbance, severe SUD, I/DD, and TBI.
- Members enrolled in a Tailored Plan can access specialized behavioral health/IDD/TBI services, including NC Innovations Waiver, TBI Waiver services, and 1915(i) services.
- 210,000 people eligible to enroll in Tailored Plans starting July 2024.

2024 | **2025**

Jan. 2024: Reimbursement Rate Increases for Behavioral Health Providers Go into Effect

- North Carolina General Assembly appropriated $220 million in recurring funds to increase Medicaid reimbursement rates for providers of mental health, SUD and intellectual/developmental disability (I/DD)-related services.

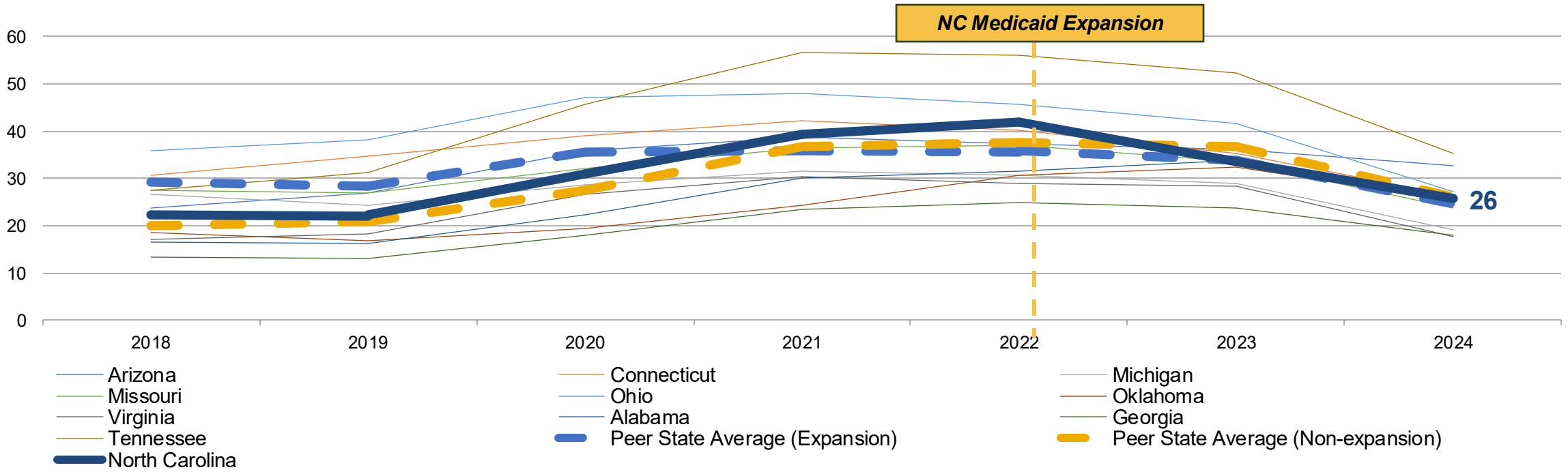
Dec. 2025: CFSP Launches

- NC begins offering a single, statewide managed care plan for NC Medicaid-enrolled children, youth, and young adults currently and formerly served by Child Welfare designed to support beneficiaries in receiving seamless, integrated and coordinated health care.
- 32,000 people were automatically enrolled in the CFSP.

North Carolina Drug Overdose Death Rates Have Rapidly Fallen

North Carolina's overdose death rate rose 87% from 2018 to 2022, faster than most Peer States, before falling 39% by 2024 to converge with the Peer State trend.

Age-Adjusted Drug Overdose Death Rate per 100,000 by State, CY 2018 to 2024



Notes: CDC mortality data reflects all North Carolina residents, not Medicaid enrollees specifically. Analyses use ICD-10 underlying cause of death codes X40 to X44 (unintentional), X60 to X64 (self-harm), X85 (assault), and Y10 to Y14 (undetermined intent) to identify drug overdose deaths.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, "Multiple Cause of Death, 2018-2024;" CDC WONDER Online Database.

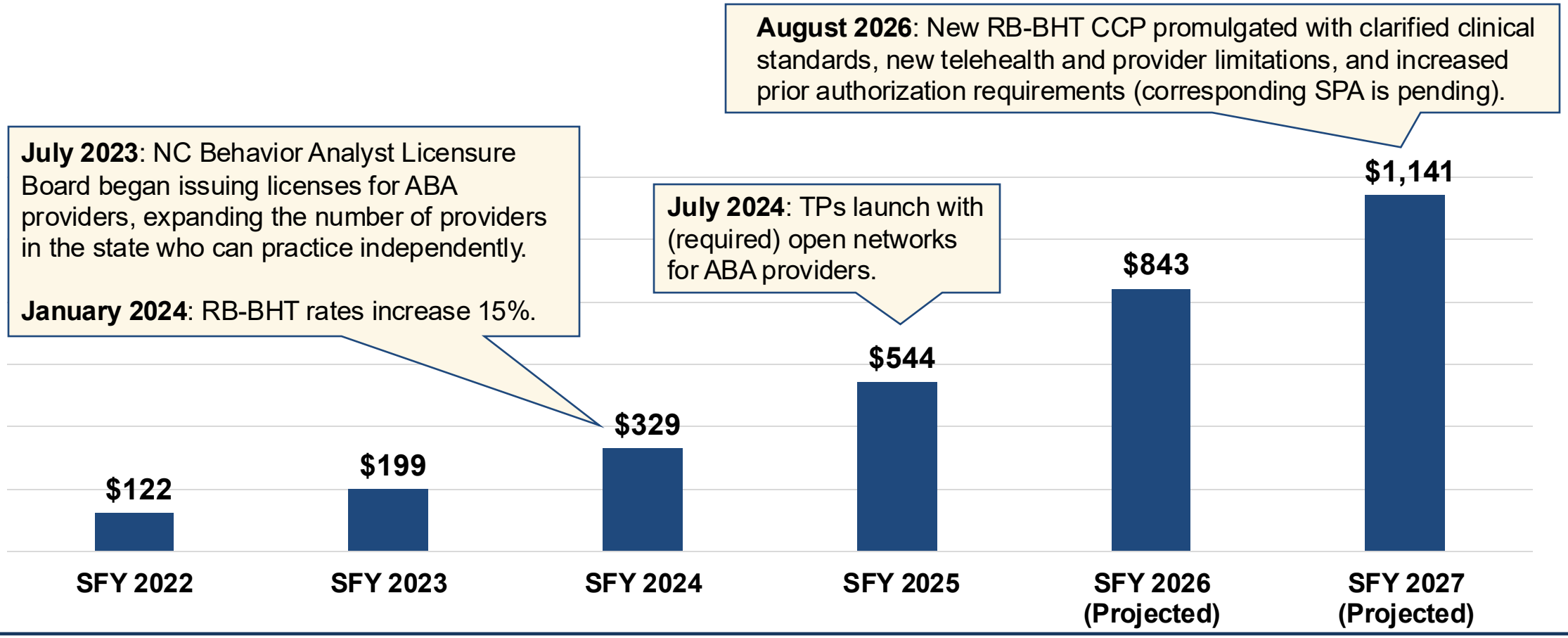
Appendix: Focus Area Findings

Research-Based Behavioral Health Treatment (RB-BHT)

NCDHHS is Responding to Rapid Growth in RB-BHT Spending

North Carolina Medicaid added RB-BHT to its State Plan in July 2017. Since then, the policy dictating delivery of the service has continued to evolve.

Total RB-BHT Medicaid Spending, SFY 2022–2027 (in millions)



Source: NCDHHS Presentation to the Joint Legislative Oversight Committee on Medicaid (2026)

Appendix: Focus Area Findings

Prescription Drugs

NC Has Kept Pharmacy Benefits Stable Since Managed Care Launched in 2021

North Carolina's Pharmacy benefit has not undergone major operational or programmatic changes since the launch of managed care in 2021.

Aug. 2024: Medicaid Begins Covering GLP-1s for Obesity Treatment

- On Aug. 1, 2024, NCDHHS expanded coverage of GLP-1s to include the indication of weight loss.

Dec. 2025: Medicaid Reinstitutes Coverage of GLP-1s for Obesity Treatment

- Governor Stein's administration reinstitutes coverage of GLP-1s for weight loss in early December 2025.



Dec. 2023: NC Expands Medicaid

- Since 2023, North Carolinians newly covered by Medicaid under expansion have filled more than 5 million prescriptions for conditions like heart disease, diabetes, seizures, and other illnesses.

Oct. 2025: Medicaid Pauses Coverage of GLP-1s for Obesity Treatment

- Medicaid coverage of GLP-1 ends due to a stalemate in budget negotiations.

Looking Forward: Increasing Use of High-cost Therapies Add Financial Pressure to the Pharmacy Benefit

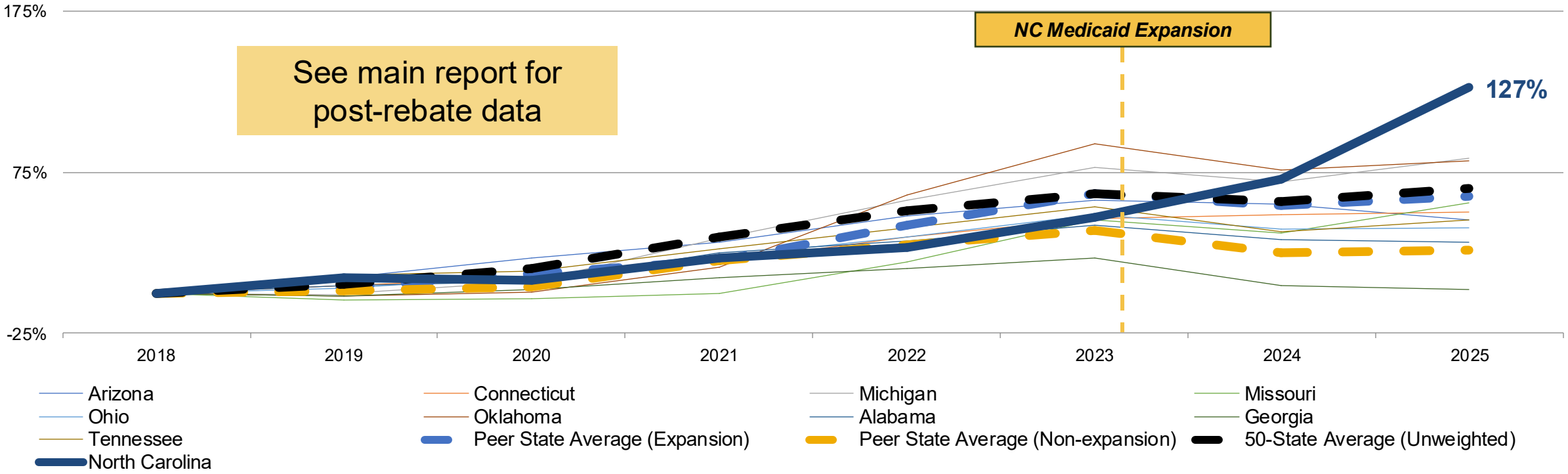
- GLP-1s, gene therapy, and immunologic agents are where there is the greatest concern.

Notes: GLP-1 = glucagon-like peptide-1.

NC Pre-Rebate Drug Spending Tracked Peer Expansion States' Until 2024

North Carolina's aggregate pre-rebate drug spending grew at about or below the rate of Peer Expansion States from 2018 to 2023, before increasing rapidly in 2024 and 2025.

Growth in Aggregate Pre-Rebate Medicaid Drug Spending Relative to 2018, CY 2018 to 2025



Notes: Trends described here reflect pre-rebate drug spending. Trends in post-rebate drug spending may differ from trends in pre-rebate spending. North Carolina expanded Medicaid in December 2023. The State Drug Utilization data contains state-submitted information on drug prescription, rebates, and payment amounts, reported at the quarter and NDC level. Records with counts less than 11 are suppressed in the data. Virginia is excluded due to likely data anomalies in its payment amounts. Peer state averages are unweighted. CY = Calendar Year.

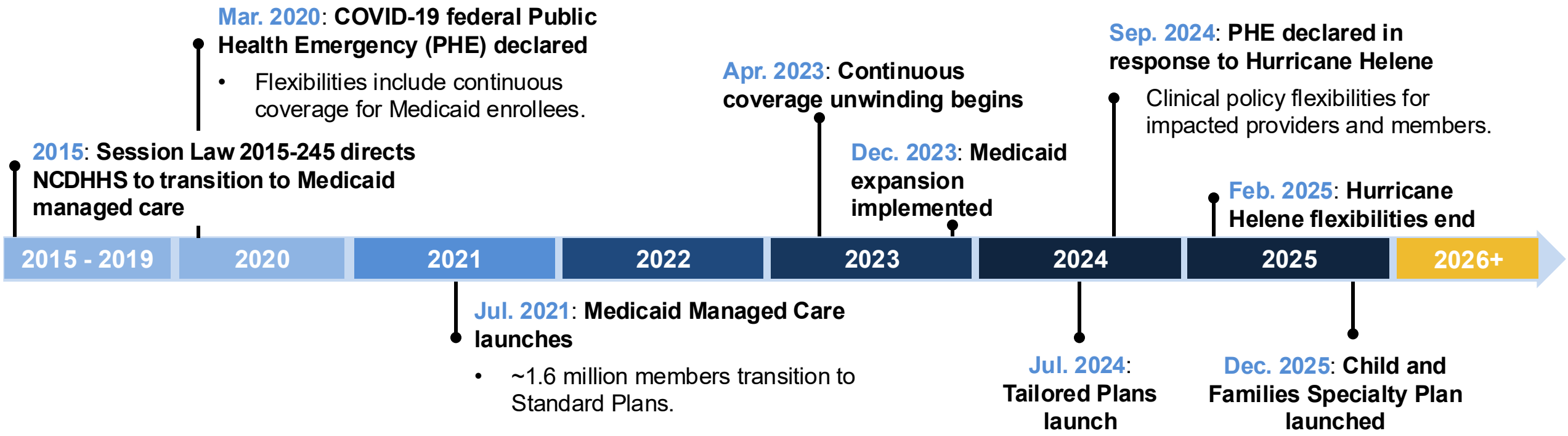
Source: Manatt analysis of CMS State Drug Utilization data.

Appendix: Focus Area Findings

Managed Care

NC Has Achieved Managed Care Transition Milestones

Over the past 11 years, North Carolina made massive financial and operational investments to transition to Medicaid managed care.



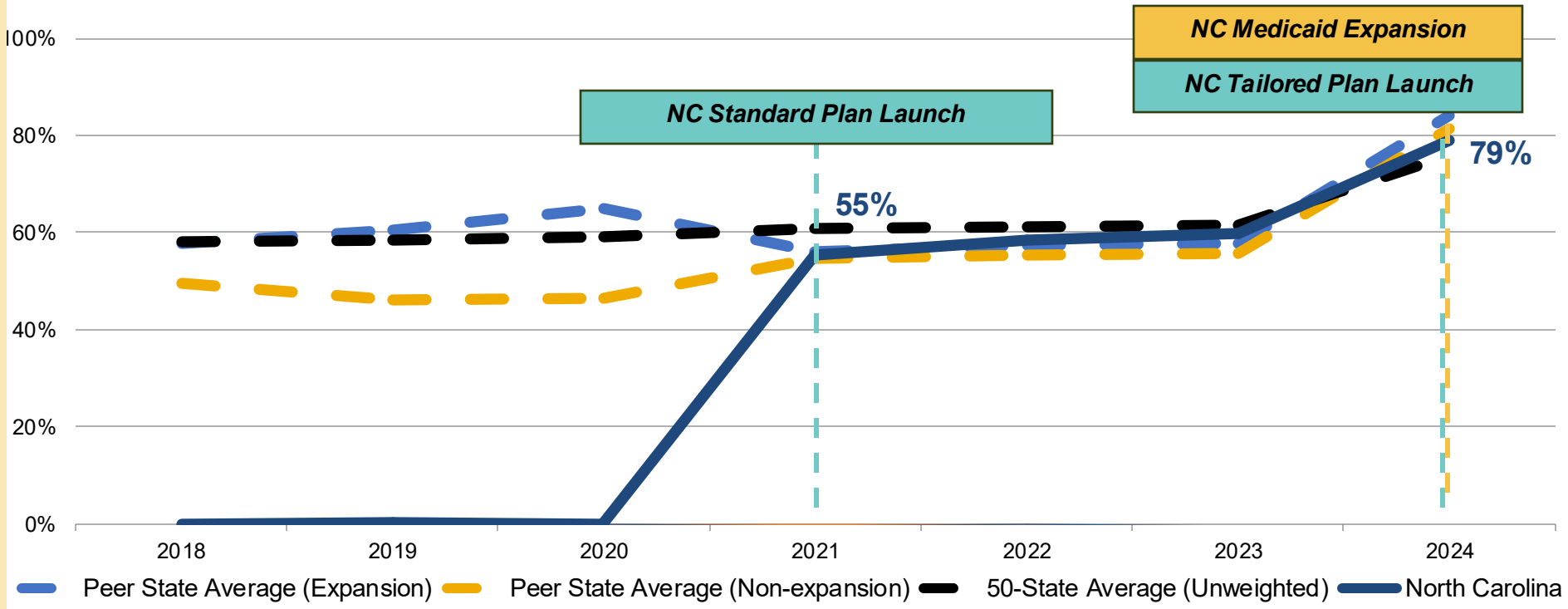
North Carolina Has Moved Most Medicaid Members into Managed Care

Since launching managed care in 2021, North Carolina has enrolled 81% of Medicaid members into three insurance products, bringing the state in line with managed care enrollment trends in comparable states.

Program Context

- North Carolina implemented managed care in July 2021, and approximately 2.48 million Medicaid members in North Carolina (81%) were in managed care as of June 2026.
- The state has three key managed care products:
  - **Standard Plans**, which launched in 2021 and now enroll 71% of members across four plans (previously five plans).
  - **Tailored Plans**, which launched in 2024 for a more complex behavioral health population and now enroll 9% of members across three plans (previously four plans).
  - **Children & Families Specialty Plan**, which launched in late 2025 and accounts for 1% of members within one plan.

Percentage of Medicaid Enrollees in a Comprehensive Managed Care Plan, FFY 2018 to 2024



Notes: Data quality of the TAF can vary by state. TAF data are subject to state-specific limitations; see the TAF Data Quality Atlas for additional details. Further information on data quality can be found in the DQ Atlas. Peer state averages are unweighted; FFY=Federal Fiscal Year; FFS=Fee-for-Service. Children and Families Specialty Plan (CFSP) enrollment is not reflected due to public data availability.

Source: MACPAC MACStats Exhibit 30 analysis of T-MSIS Analytic Files; KFF State Health Facts analysis of Medicaid Managed Care Reports; North Carolina Medicaid Enrollment Dashboard.

North Carolina Has Built Population Health Infrastructure

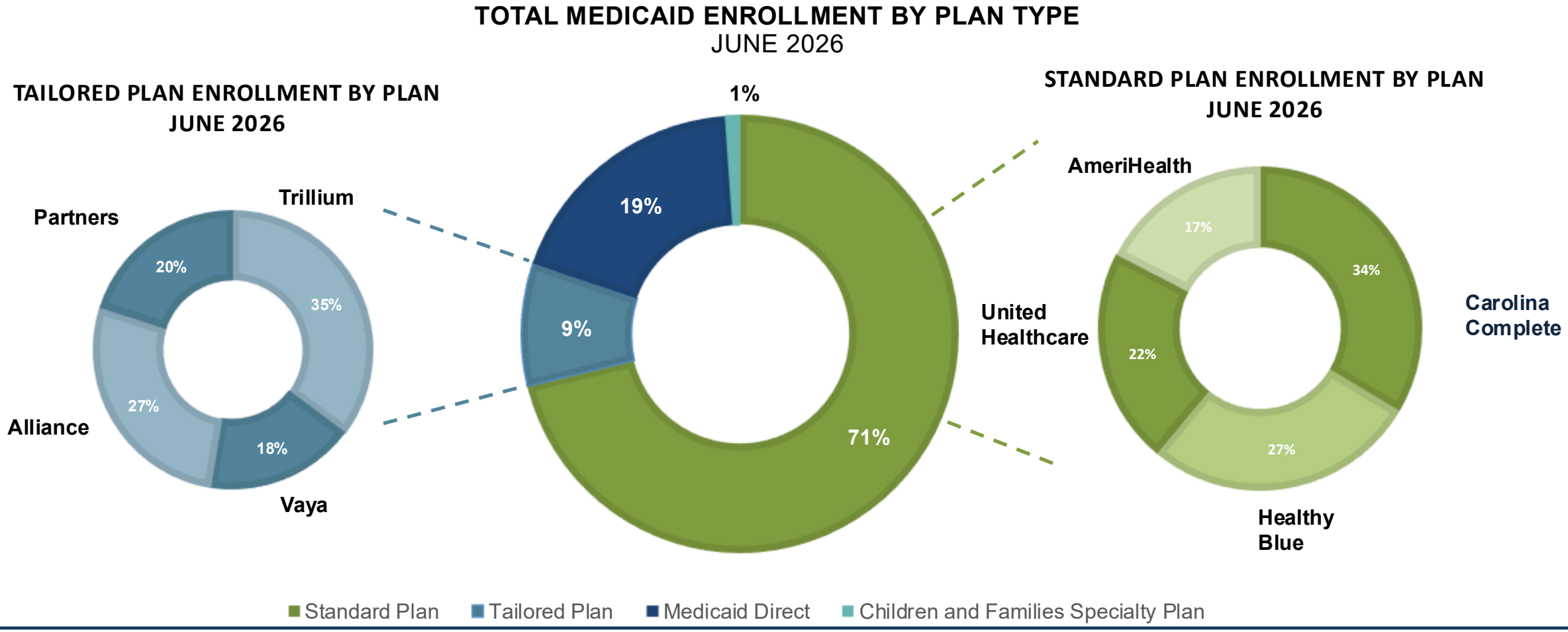
Population Health Infrastructure is a foundational component of North Carolina's health care system for Medicaid enrollees, supporting high-quality delivery of the right care at the right place, at the right time, and in the right setting.

	Medicaid Managed Care and Care Management			Medicaid FFS
	Standard Plans	**Tailored Plans**	**Children & Families Specialty Plan (CFSP)**	**NC Medicaid Direct**
Eligibility	Majority of Medicaid population	Individuals with significant behavioral health needs, I/DD, or TBI	Children, youth, and families served by the child welfare system	Individuals delayed, excluded, or exempt from integrated Medicaid Managed Care
Care Management	Advanced Medical Home Program	Tailored Care Management	CFSP Care Management	
Population Eligible for CM	Standard Plan members with **high-needs**	**All** Tailored Plan members	**All** CFSP members	NC Medicaid Direct enrollees with **high-needs**
Care Management Providers	• Standard Plan • Advanced Medical Home (AMH Tier 1, 2, or 3)	• Tailored Plan • Advanced Medical Home+ (AMH+) • Care Management Agency (CMA)	• Children & Families Specialty Plan	• Prepaid Inpatient Health Plans (PIHP) • Community Care of North Carolina (CCNC) • AMH+ • CMA

The Department also partners with the Cherokee Indian Hospital Authority on the **EBCI Tribal Option**, a non-risk bearing managed care option for federally recognized tribal members and other individuals eligible to receive services from the Indian Health Service. The EBCI Tribal Option has a strong focus on primary care, preventive health and chronic disease management and provides care management for all members and support services for high-need members.

Most NC Members Are In Standard Plans

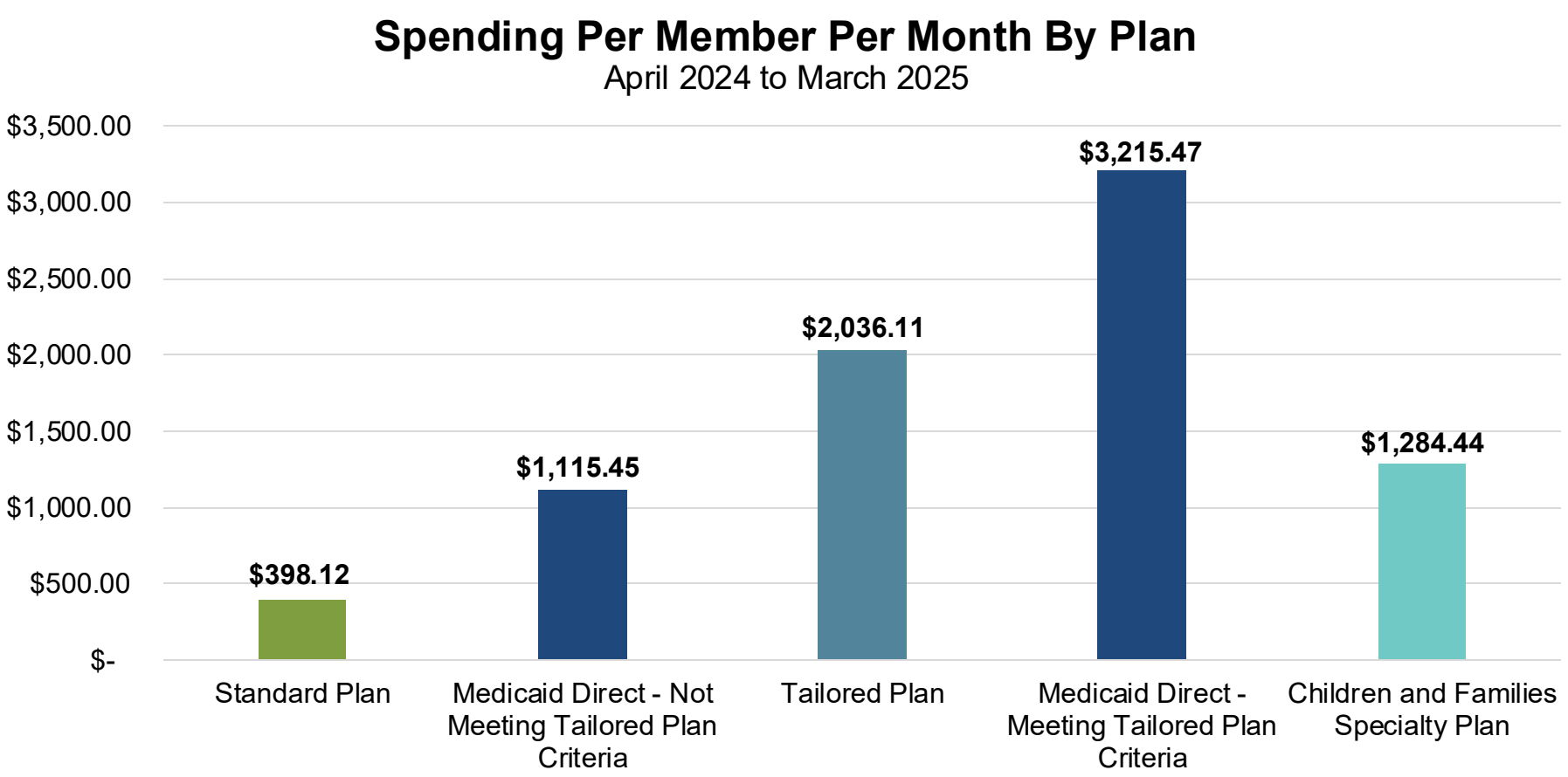
As of June 2026, the majority of North Carolina Medicaid members (70%) are enrolled in a Standard Plan, followed by Medicaid Direct (19%).



Source: North Carolina Medicaid Enrollment Dashboard.

Standard Plans Spent Less Per Member Per Month Than Medicaid Direct in 2023–2024

Medical costs are lower in managed care plans; however, members in FFS tend to have more significant health care needs. Moreover, this data does not reflect administrative costs.



Program Context

- Consistent with the Marsh analysis on the value of managed care, data suggest that medical spending is lower for members enrolled in managed care compared with those in fee for service (FFS, or Medicaid Direct).
- However, members enrolled in FFS include Medicare-Medicaid dual eligibles and special populations more likely to require costly medical services.

Source: Analysis of Marsh BY 2025 UBDS report.

Standard Plans Outperformed FFS on Most Quality Measures From 2022 to 2024

Members in Standard Plans generally perform better on quality measures than members in FFS. However, differences in the populations enrolled in Standard Plans v. FFS may account for these differences.

	2022			2023			2024		
	Standard Plans^	FFS	National Medicaid HMO Average	Standard Plans^	FFS	National Medicaid HMO Average	Standard Plans^	FFS	National Medicaid HMO Average
Cervical Cancer Screening	49.2%	22%	56%	53.2%	28%	55%	48.6%	31%	57%
Child and Adolescent Well-Care Visits	50.6%	43%	49%	53.8%	52%	52%	56.2%	53%	55%
Childhood Immunization Status, Combination 10	26.4%	34%	32%	24.8%	27%	29%	24.6%	26%	28%
Chlamydia Screening in Women	58.6%	52%	56%	61.8%	55%	57%	63.4%	56%	57%
Colorectal Cancer Screening	-	-	-	31.2%	14%	39%	36.4%	18%	42%
Follow-Up After Hospitalization for Mental Illness – 7 days	32.2%	23%	37%	32%	22%	39%	28.2%	21%	41%
Follow-Up After Hospitalization for Mental Illness – 30 days	53.6%	40%	57%	52.6%	41%	59%	49.2%	40%	61%
Immunizations for Adolescents, Combination 2	29.4%	30%	36%	30%	31%	36%	31.8%	32%	38%
Prenatal and Postpartum Care, Postpartum Care	64.6%	50%	77%	66.4%	51%	79%	72.4%	53%	81%
Prenatal and Postpartum Care, Timeliness of Prenatal Care	52.2%	42%	83%	53.4%	43%	83%	60.6%	46%	85%
Well Child Visits, 15-30 months	68.8%	72%	67%	70.4%	74%	69%	73%	79%	73%
Well Child Visits, First 15 months	63%	52%	57%	66.4%	54%	59%	68.2%	56%	62%

^Average Standard Plan performance

Average Standard Plan performance is better than FFS

Average Standard Plan performance is worse than FFS

Source: Manatt analysis of NCDHHS Quality Measures Dashboard, updated 5/28/2026.

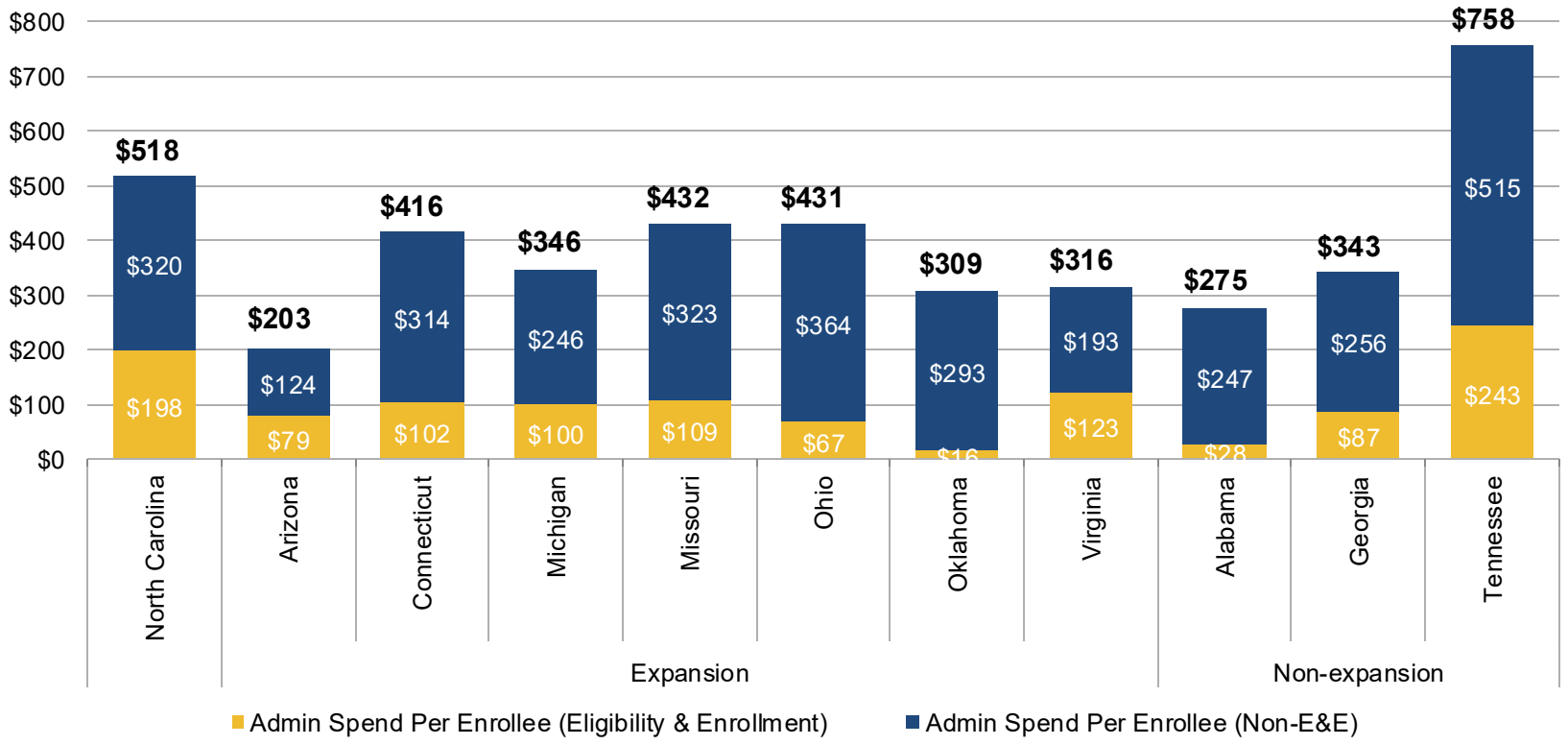
Appendix: Focus Area Findings

Administration & State Operations

A Large Portion of NC Medicaid Administrative Spending Per Enrollee is for E&E

North Carolina Medicaid's statewide administrative spending per enrollee is higher than most Peer States, driven in part by higher E&E spending.

Medicaid Total Administrative Spending Per Enrollee, FFY 2024



State	Per-Enrollee Total Admin Spend (FFY 2024)
Tennessee	$758
North Carolina	**$518**
Missouri	$432
Ohio	$431
Connecticut	$416
Michigan	$346
Georgia	$343
Virginia	$316
Oklahoma	$309
Alabama	$275
Arizona	$203

Notes: Administrative spending includes expenditures related to state eligibility systems, MMIS, EHR incentive programs, and other administrative functions. Full-year equivalent (FYE) may also be referred to as "average monthly enrollment." TAF data are subject to state-specific limitations; see the TAF Data Quality Atlas for additional details. Eligibility groups based on MACPAC approach for summing full year equivalent enrollees by eligibility group. Peer state averages are unweighted. FFY = Federal Fiscal Year.

Source: MACPAC MACStats Exhibit 31 analysis of CMS-64 MBES reports; MACStats Exhibit 15 and Manatt analysis of T-MSIS Analytic Files.