



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

Stakeholder Engagement Webinar

September 3, 2026

Agenda

- Overview of the North Carolina Medicaid Assessment
- Background on North Carolina Medicaid
- Landscape Analysis Findings
- Opportunities for Stakeholder Engagement
- Q&A

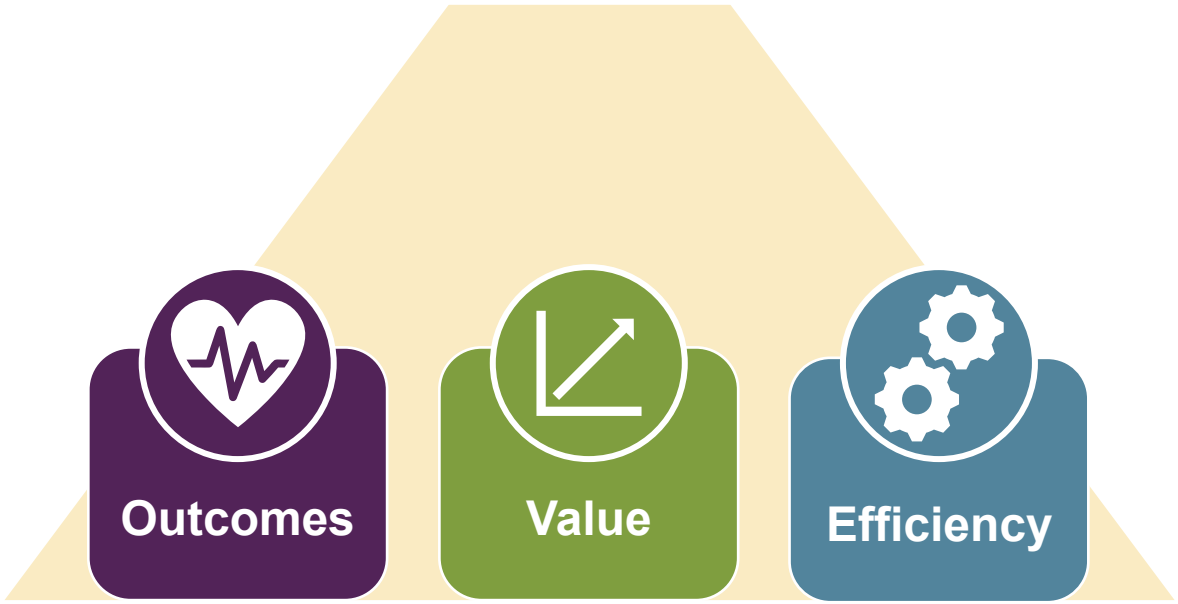
Overview of the North Carolina Medicaid Assessment

NC Medicaid Assessment

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:



Opportunities to Contribute to the Assessment

Guiding Principles

The Guiding Principles help the state evaluate and prioritize potential policy and program proposals.

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

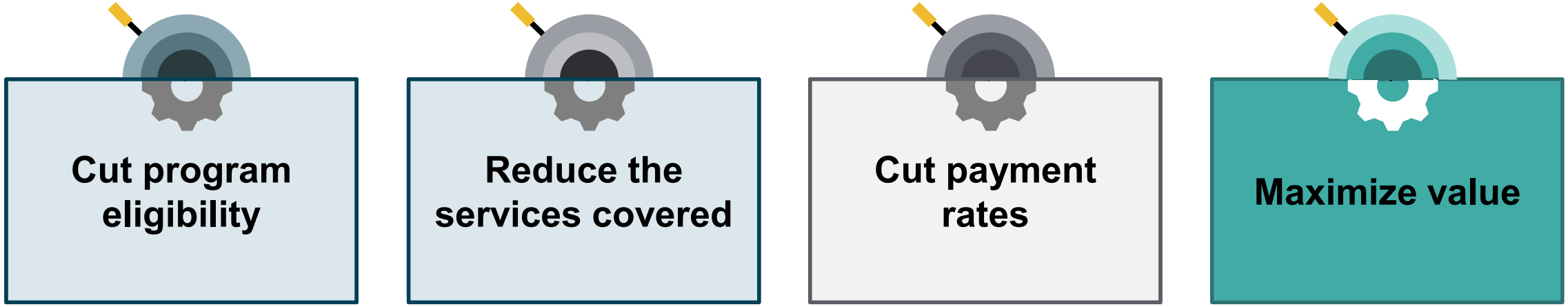
Ensure good stewardship: Optimize program administration, slow cost growth, address cost drivers, and enable a high performing program

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

Policy and Program Levers Available to States to Manage Medicaid Costs

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



Focus of this Project: 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.

Phase 1: Landscape Analysis

The project will analyze 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
- **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	**Prescription Drugs**
Long-Term Services and Supports (LTSS)	**Behavioral Health**
Population Health and Primary Care	**RB-BHT**
Delivery System Factors	
Administrative Services	
Managed Care	

Background on North Carolina Medicaid

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 NC's Workforce & Economy

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

Medicaid Expansion Makes Care Accessible

- **North Carolina's uninsured 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 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 shifts 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
- **Increasing costs for labor, medical supplies, and prescription drugs** nationwide.

Federally mandated changes continue to impact Medicaid, including program eligibility, operations, and funding.

- North Carolina was able to stretch General Fund dollars further using temporary, enhanced federal match 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 NC Medicaid

- 255,000 North Carolinians may lose Medicaid coverage
- $55 billion may be lost in Medicaid funding 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

Landscape Analysis Findings

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, and prescription drugs.

- **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 revenue* 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 have recently shifted costs to the state.** Looking ahead, H.R. 1's cuts to state directed payments 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.** Variations in costs, rates of cost growth, and outcomes, across service lines and populations indicate opportunities to enhance the program effectiveness and efficiency.

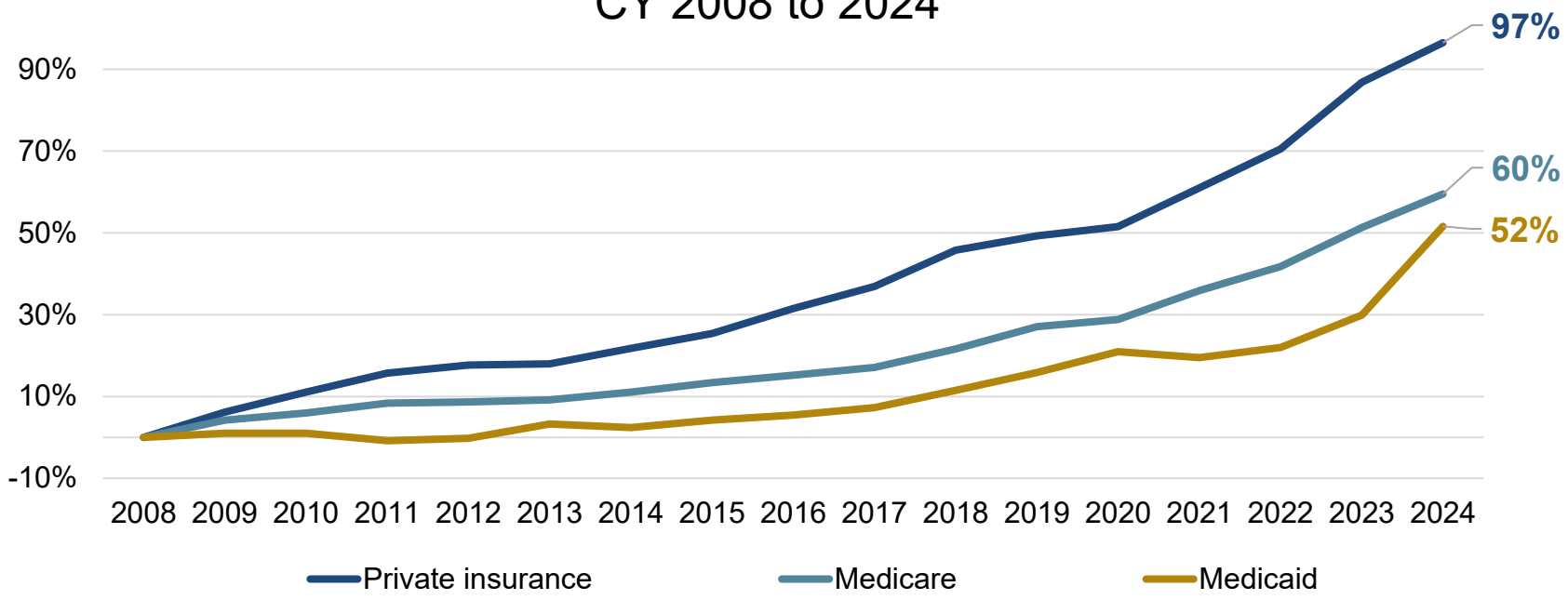
Medicaid Not Immune From Health Care Cost Growth Pressures

Americans in every state are facing increasingly 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



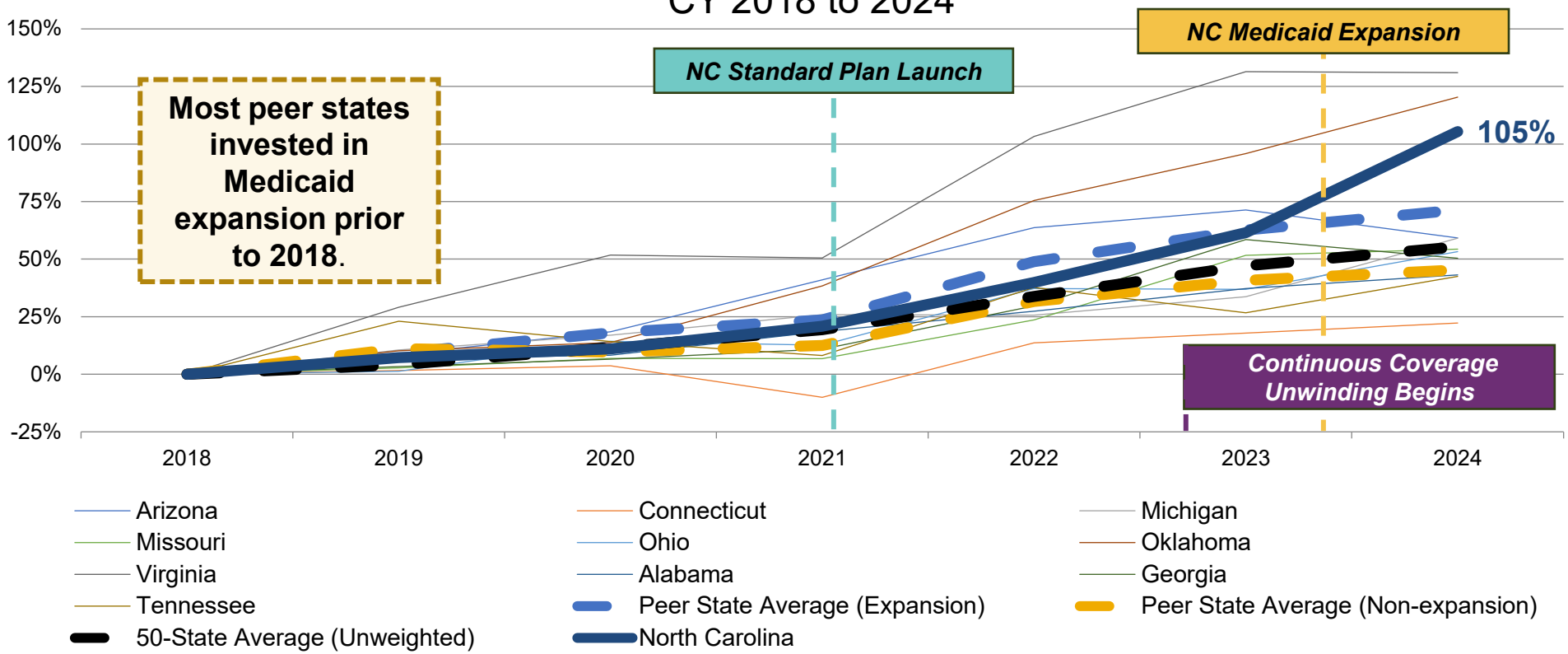
Notes: CY = Calendar Year; See Notes in Appendix

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;

Total Medicaid Spending by State

Total Medicaid spending in North Carolina grew in-line with most Peer States 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



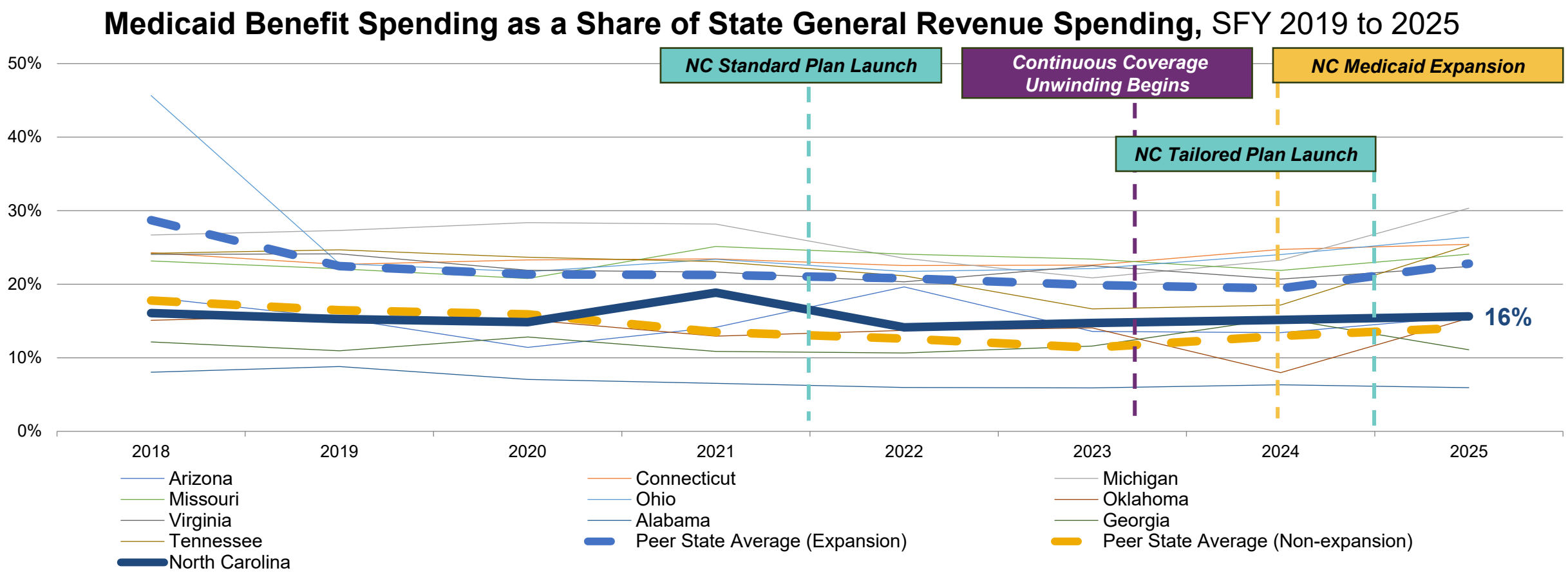
State	Spending (CY 2024)
North Carolina	$27.6B
Alabama	$8.2B
Arizona	$20.0B
Connecticut	$10.8B
Georgia	$16.4B
Michigan	$26.8B
Missouri	$16.0B
Ohio	$34.8B
Oklahoma	$10.6B
Tennessee	$13.5B
Virginia	$21.6B

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.

Medicaid as a Share of State General Revenue Spending by State

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



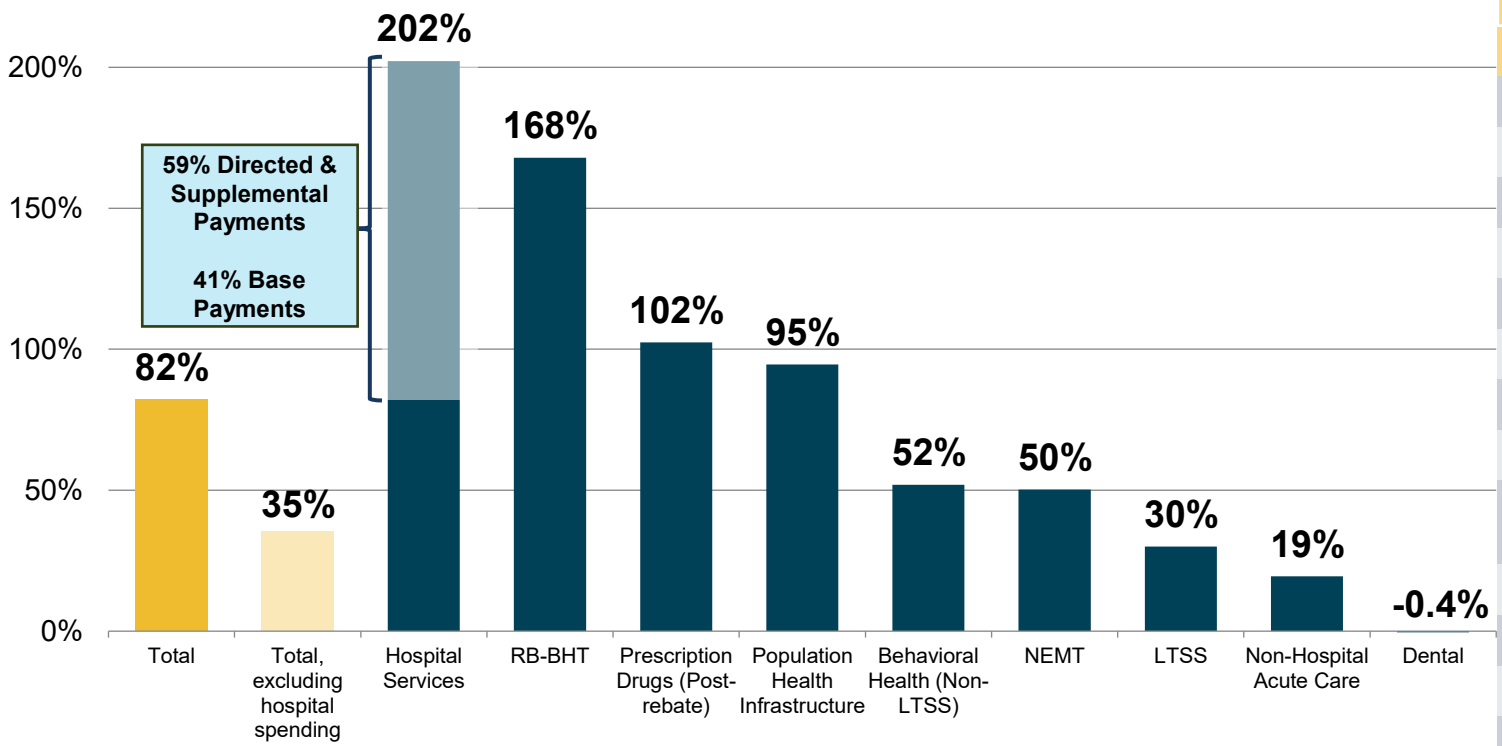
Notes: SFY = State Fiscal Year; See Notes in Appendix

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

North Carolina Medicaid Cost Growth Drivers

Variations in costs, rates of cost growth, and outcomes, across 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
HCBS LTSS	28%	$3,131M
Institutional LTSS	32%	$3,276M
Prescription Drugs (Post-rebate)	102%	$2,245M
Behavioral Health (Non-LTSS)	51%	$2,125M
Research-Based Behavioral Health Treatment	168%	$539M
Non-Hospital Acute Care	19%	$2,902M
Pop. Health Infrastructure	95%	$742M
Non-Emergency Medical Transportation	50%	$143M
Dental	-0.4%*	$541M

Notes: See Notes in Appendix

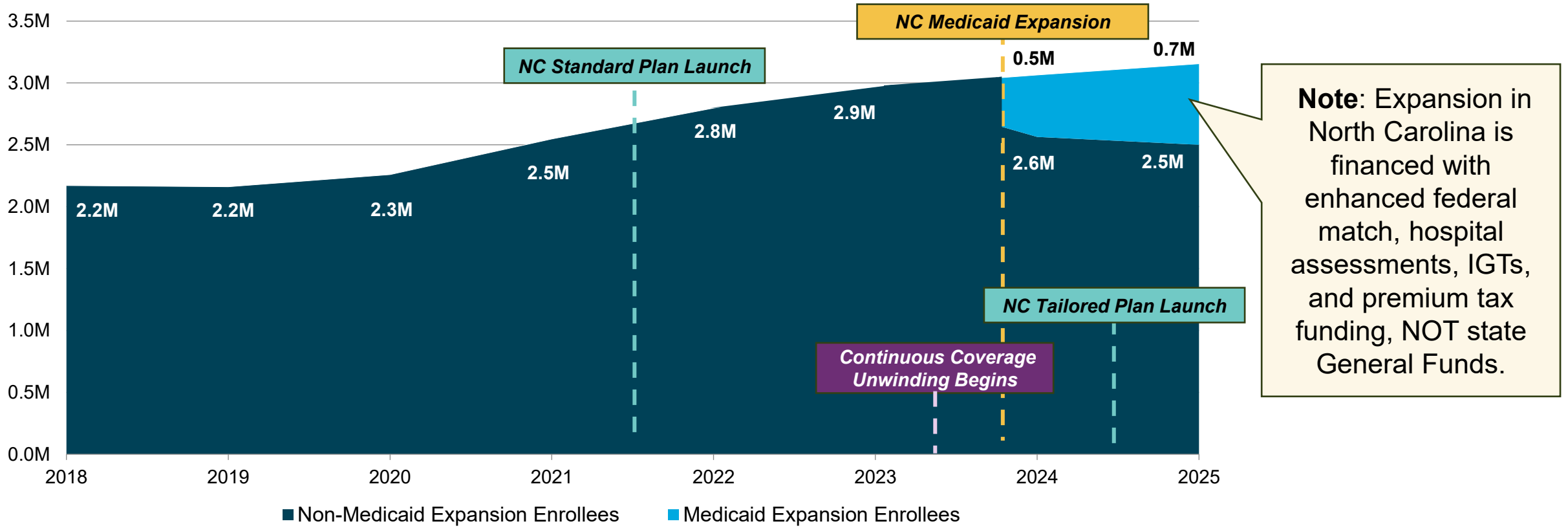
Source: North Carolina spending by service category from Mercer UBDS Reports; Hospital FFS supplemental payments from CMS-64 MBES Reports; Hospital directed payments from analysis of CMS preprints.

Enrollment and Spending

Medicaid Enrollment Growth 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 vs. Non-Expansion Enrollment, CY 2018 to 2025



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

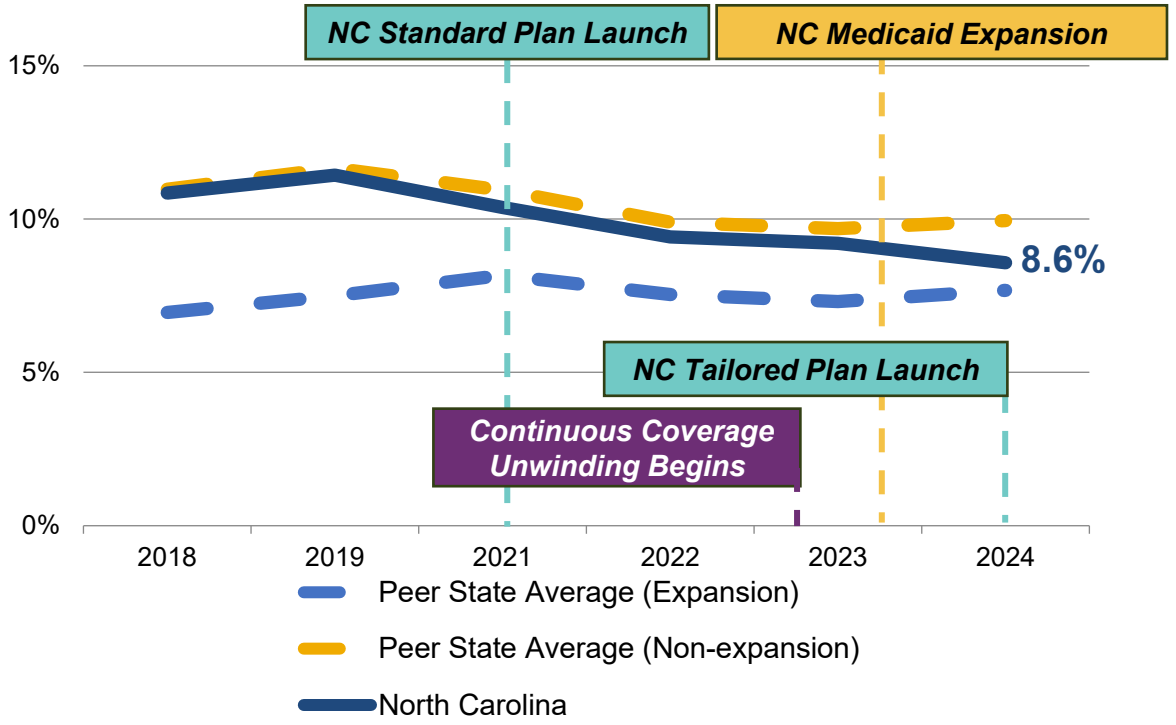
Notes: CY = Calendar Year; See Notes in Appendix

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

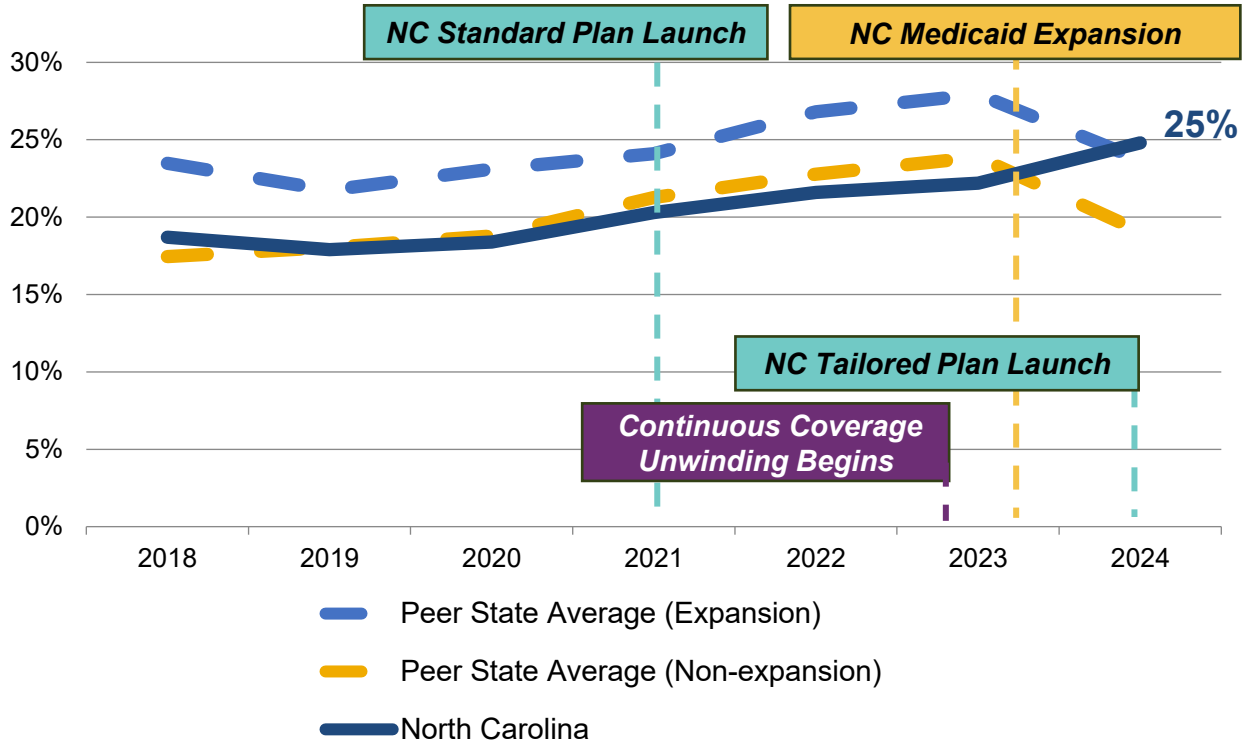
Medicaid Enrollment and Uninsured Rates by State

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 Uninsured Individuals by State, CY 2018 to 2024



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

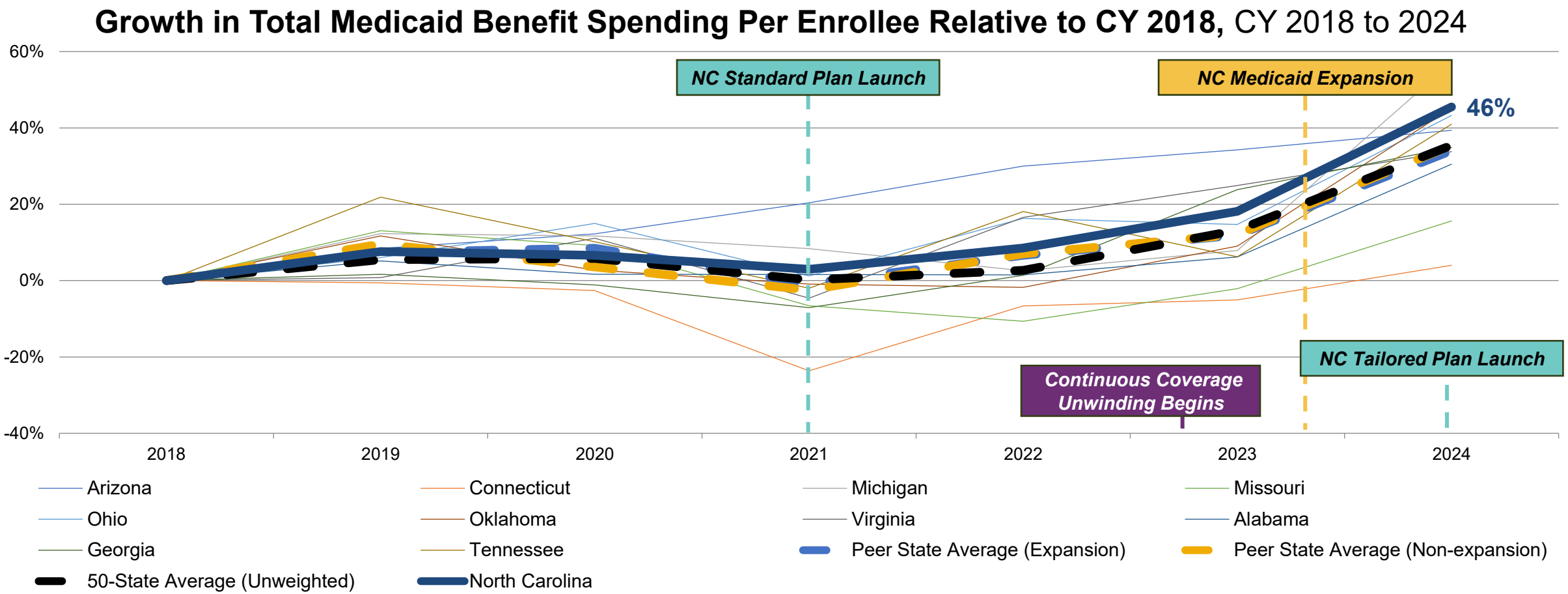


Notes: CY= Calendar Year; See Notes in Appendix

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

Growth In Total Medicaid Spending per Enrollee by State

North Carolina's growth in total Medicaid spending per enrollee was higher than Peer Expansion States.

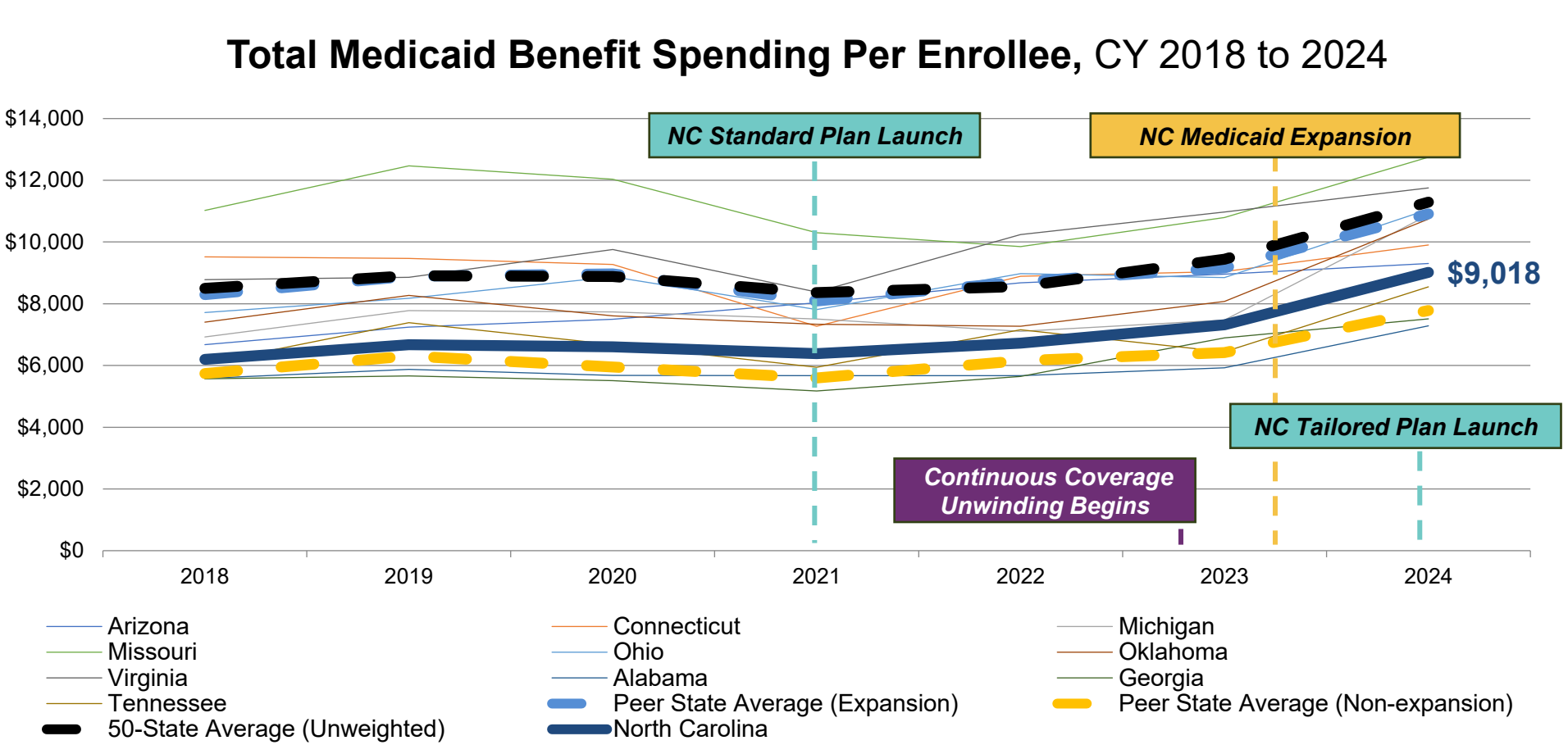


Notes: CY = Calendar Year; See Notes in Appendix

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

Medicaid Total Spending per Enrollee by State

North Carolina's per enrollee spending remained below most Peer States.



State	Spending per Enrollee (CY 2024)
North Carolina	$9,018
Alabama	$7,285
Arizona	$9,304
Connecticut	$9,904
Georgia	$7,510
Michigan	$10,876
Missouri	$12,749
Ohio	$11,054
Oklahoma	$10,744
Tennessee	$8,548
Virginia	$11,753

Notes: CY = Calendar Year; See Notes in Appendix

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

Focus Area Analyses

Focus Area Analysis Overview

Focus Area analyses sought to identify North Carolina Medicaid's primary cost centers and drivers, and 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).

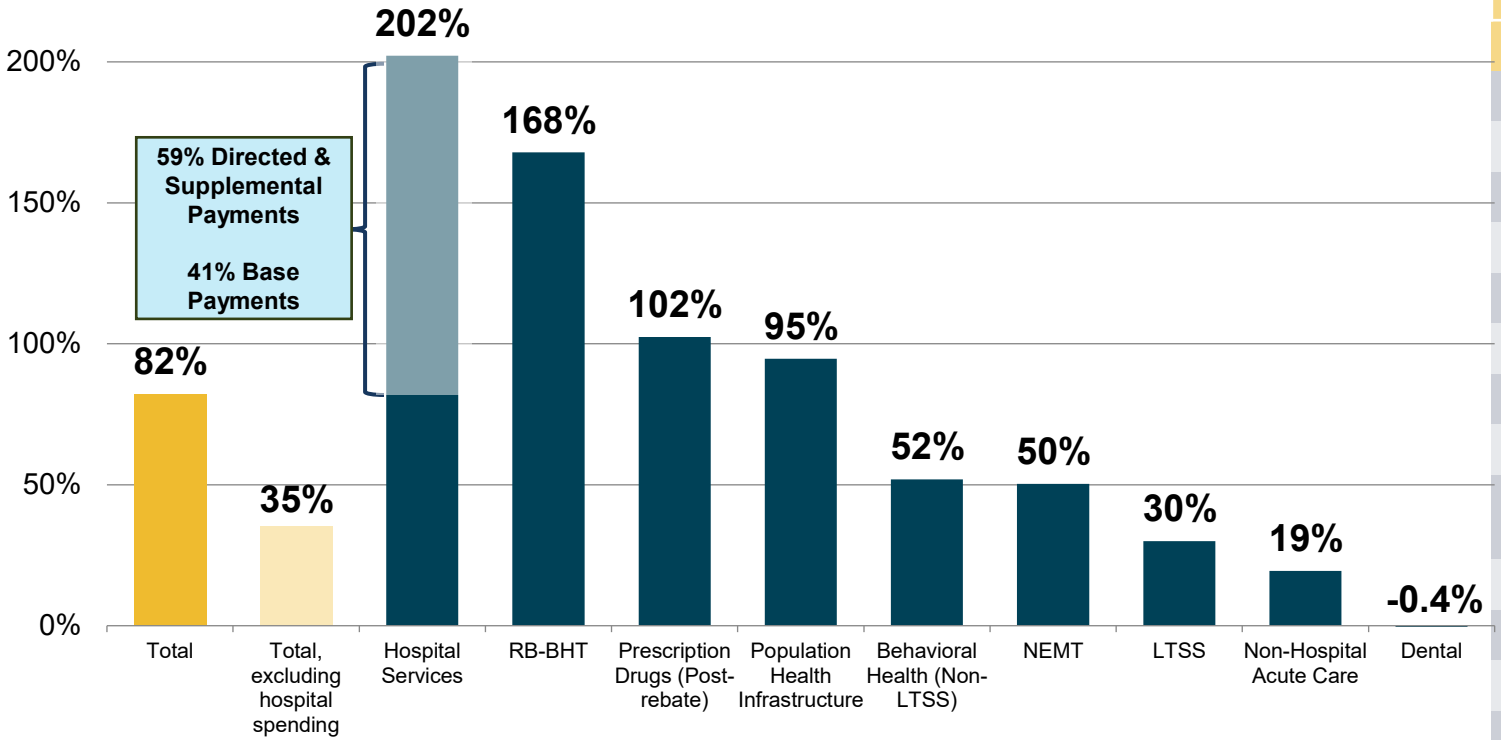
Cost Centers	Cost Growth Drivers
Services that account for a disproportionate share of Medicaid spending.	Services that account for a disproportionate share of Medicaid spending growth.

- **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.

North Carolina Medicaid Cost Growth Drivers

From 2019 to 2025, spending growth associated with hospital services, RB-BHT, prescription drugs, and population health infrastructure outpaced growth in overall Medicaid spending per enrollee.

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



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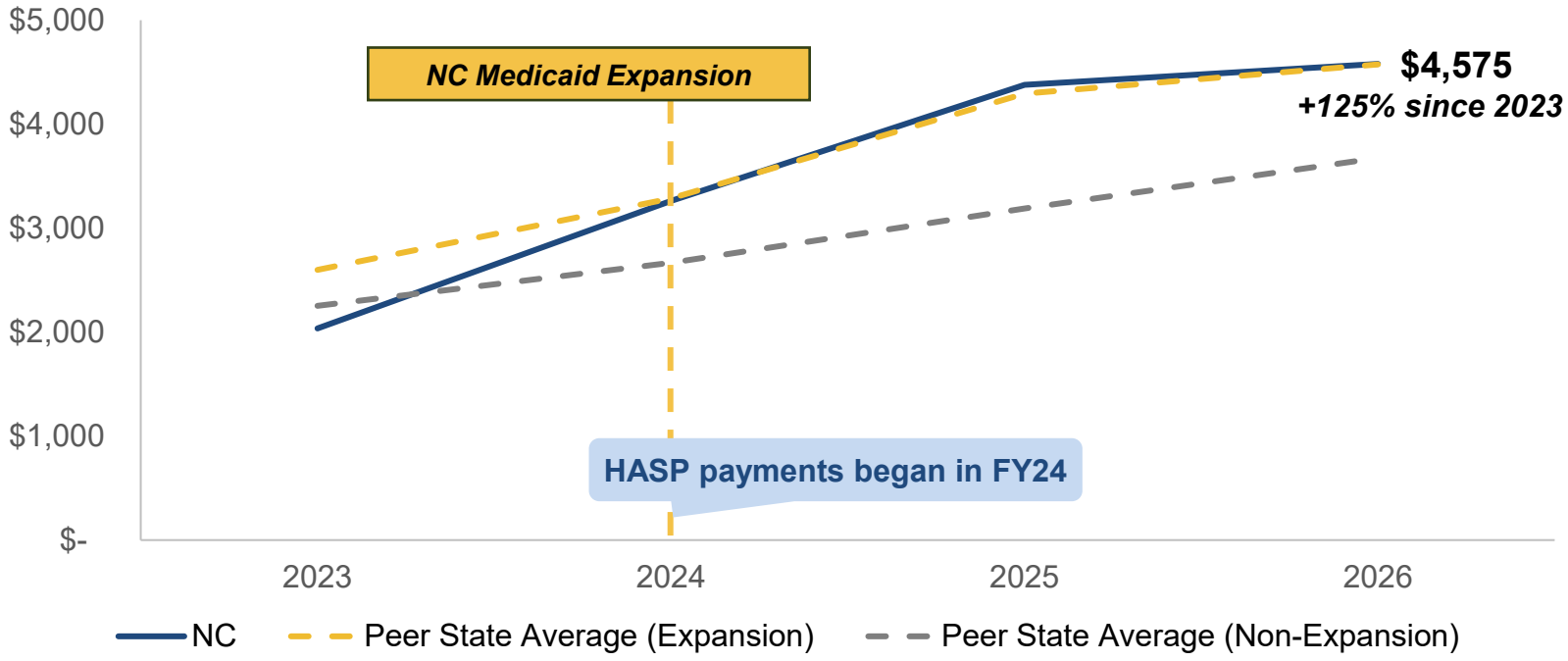
Notes: See Notes in Appendix

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

NC Medicaid Hospital Spending Growth

Per enrollee hospital spending more than doubled since 2023, though both per enrollee and total spending remain in-line with Peer Expansion States.

Total Medicaid Hospital Spending Per Enrollee, FFY 2023 to 2026



Hospital Spending as a % of Total Medicaid Benefit Spending, FFY26

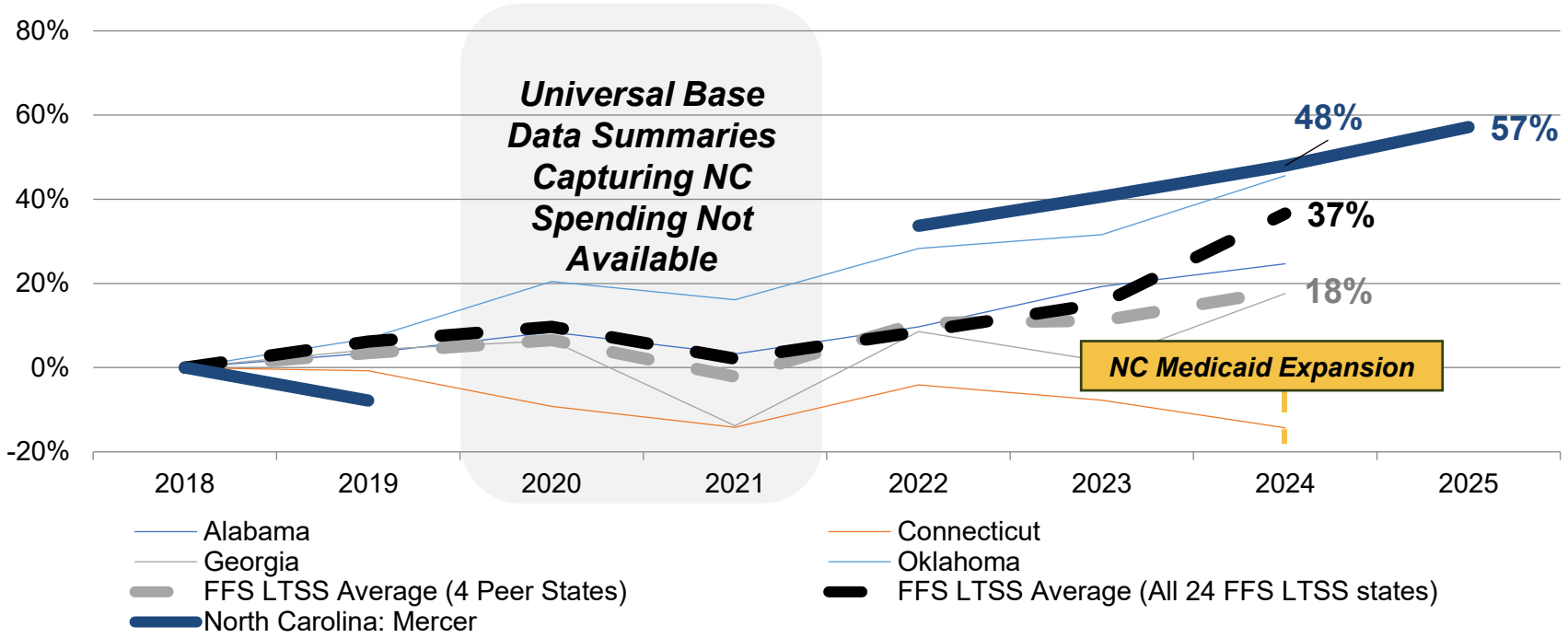
State	% of Total Medicaid Spend
Peer State Avg. (Expansion)	37%
NC	**39%**
Peer State Avg. (Non-Expansion)	42%

Notes: See Notes in Appendix

Institutional LTSS Spending Growth Per Enrollee by State

North Carolina's institutional LTSS spending per aged or disabled enrollee has grown faster than fee-for-service (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%

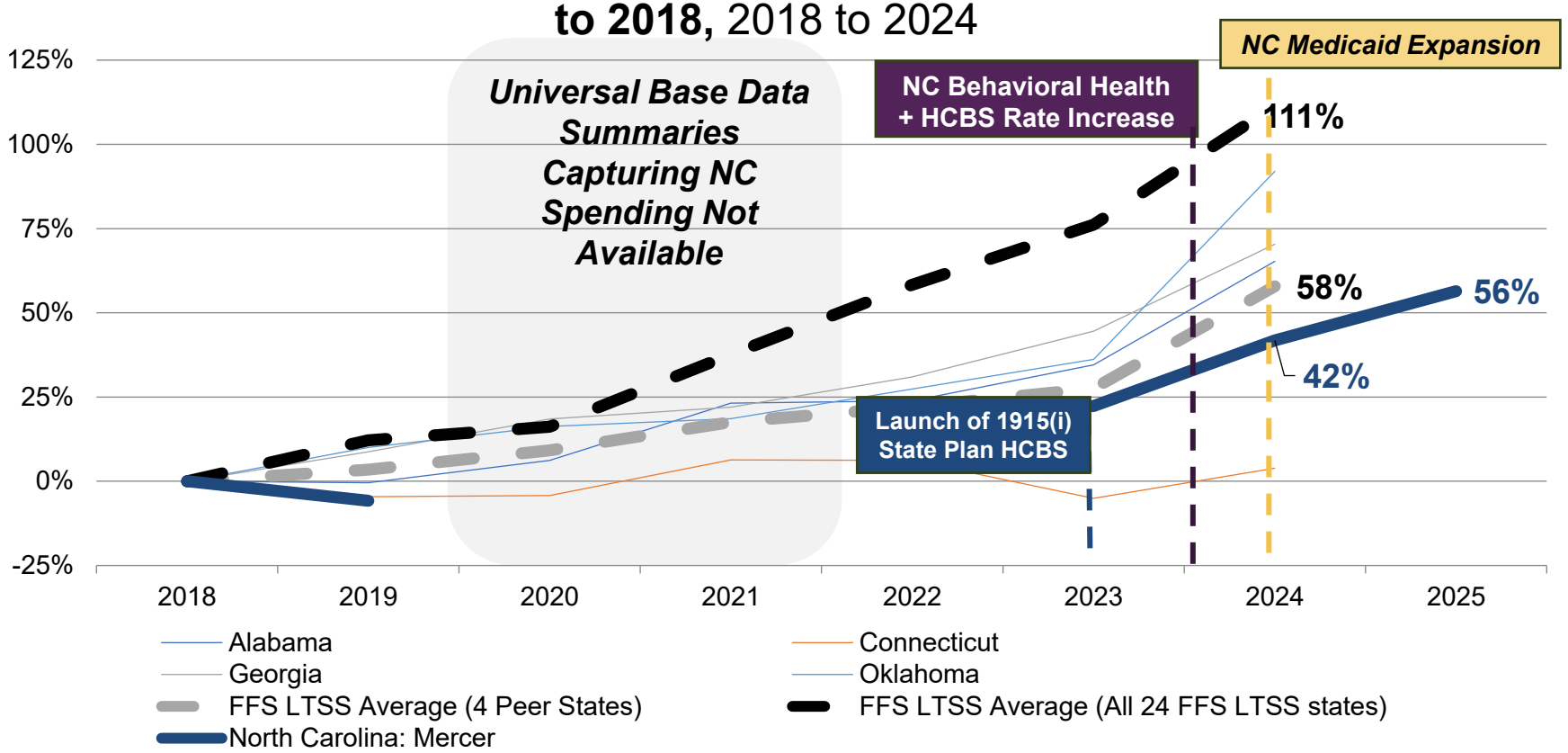
Notes: FFS = Fee-For-Service; LTSS = Long-Term Services and Supports; LTRDS = Long-Term Residential and Day Supports; See Notes in Appendix

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

Community LTSS Spending Growth Per Enrollee by State

North Carolina Medicaid's Home and Community Based Service (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; See Notes in Appendix

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

LTSS Performance by State

North Carolina ranked 41st in AARP's 2023 LTSS scorecard but has since invested in improving access for eligible populations through system improvements and other investments.

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

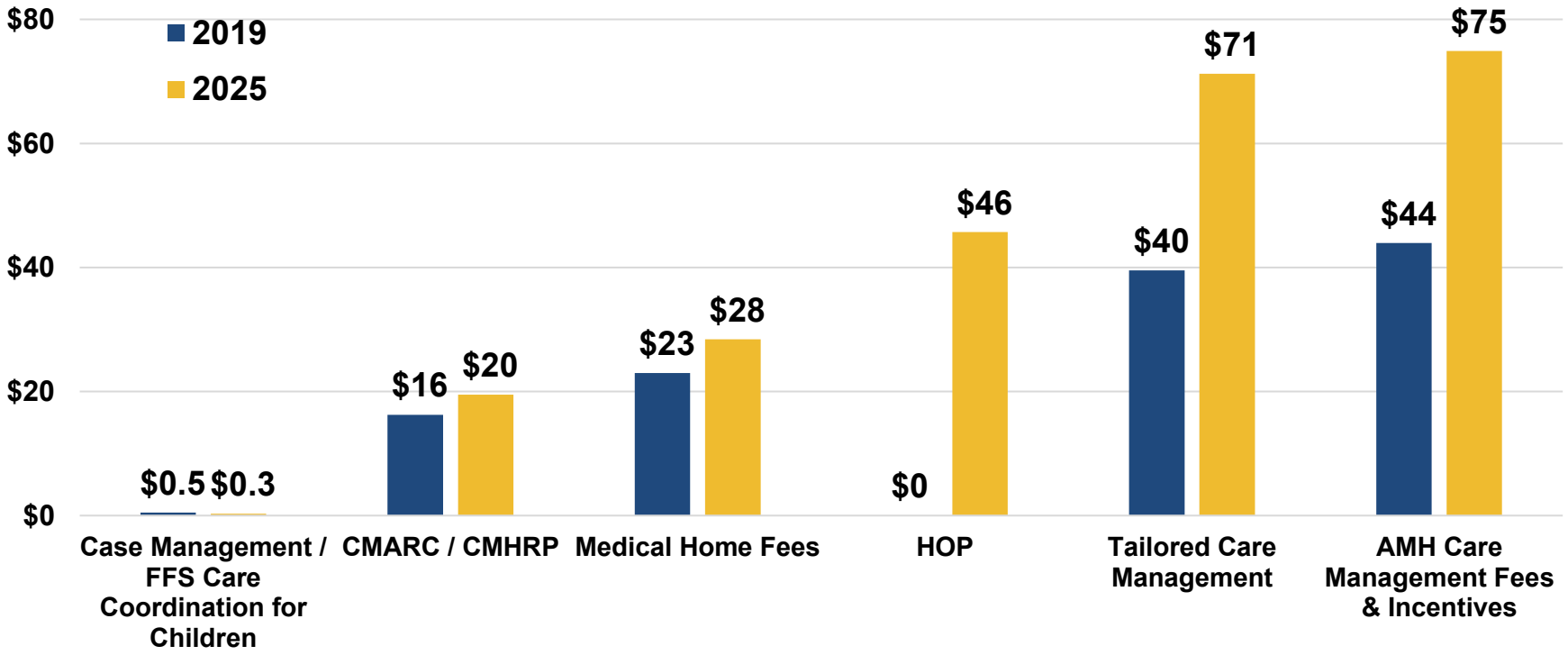
Notes: LTSS = Long-Term Services and Supports. CY = Calendar Year; See Notes in Appendix

Source: AARP LTSS 2023 State Scorecard Report.

Population Health Investments

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, 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;** other program evaluations are underway.

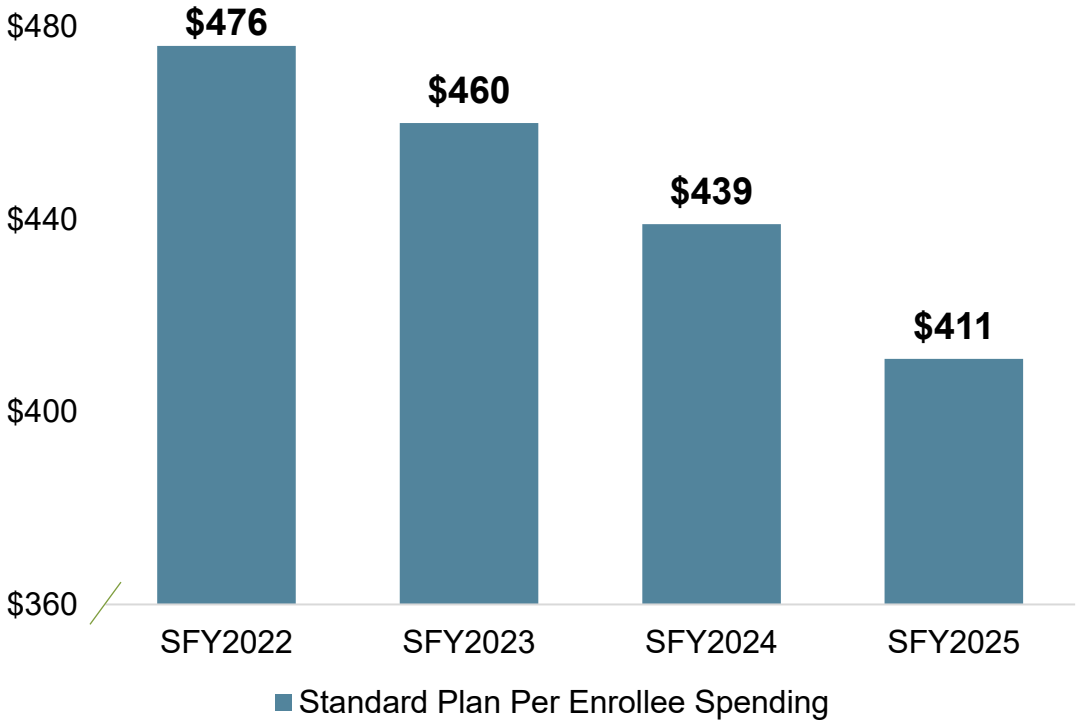
Notes: CMHRP = Care Management for High-Risk Pregnancies. CMARC = Care Management of At-Risk Children. TCM = Tailored Care Management; See Notes in Appendix

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

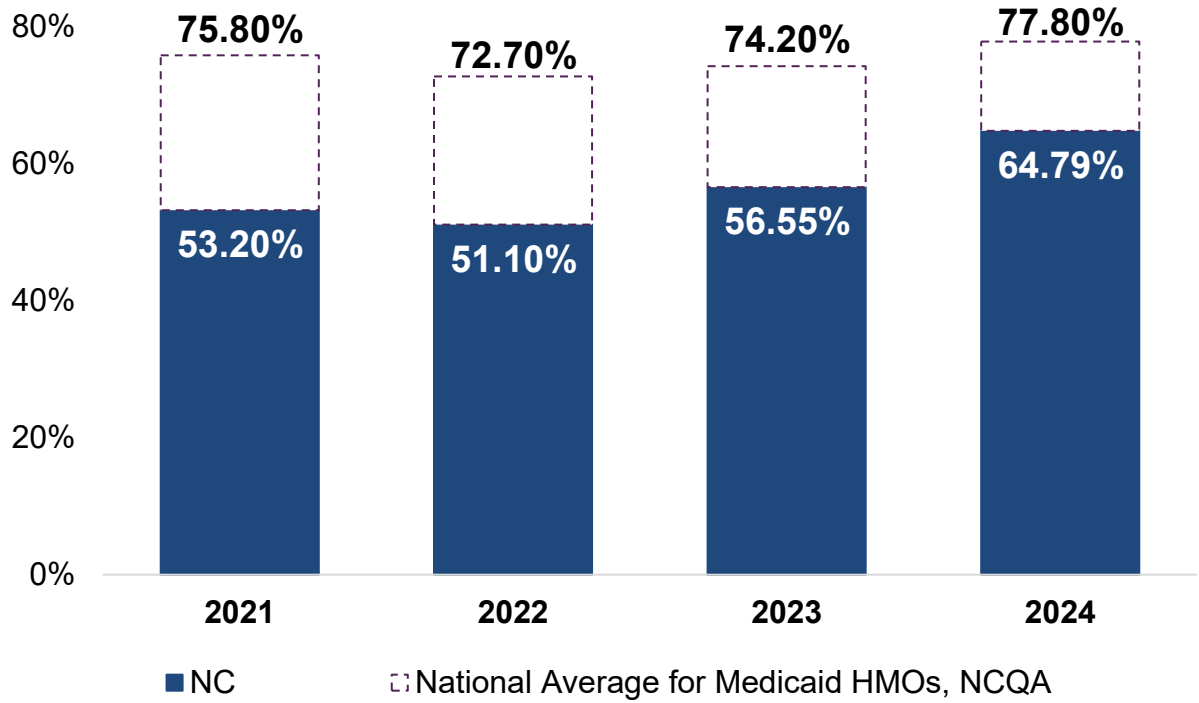
Primary Care Spending and Ambulatory Access

North Carolina's primary care spending in Standard Plans appears to be declining; access remains below the national average despite recent gains.

Standard Plan Primary Care Expenditure Reporting,*
SFY 2022 to 2025



NC Medicaid Rate of Adult Access to Preventive/Ambulatory Health Services (AAP),**
CY 2021 to 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 visit (e.g., annual physical exams, evaluation and management visits).
Source: NC Medicaid Quality Fact Sheets: Access to Care; NCQA HEDIS Measure Library & Historical Data

NC Pharmacy Benefit Performance

North Carolina's pharmacy program performs better on some and below on other key national performance indicators.

Medicaid Pharmacy Key Performance Indicator	North Carolina	National Average (est.)
Prescriptions per Beneficiary per Year	**6.95**	10
Average Gross Spending per Member per Month (PMPM)	**$137**	$115
Average Gross Cost per Prescription	**$189**	$136
PMPM Net Cost per Prescription	**$56.78**	$61
Specialty Drug Utilization as a Percent of Paid Amount	**52.66%**	45-60%^
Mental Health Drug Utilization as a Percent of Paid Amount	**11.89%**	10-15%^
Generic Dispensing Rate	**90.95%**	86-87%
PDL Compliance Rate	**95.94%**	*

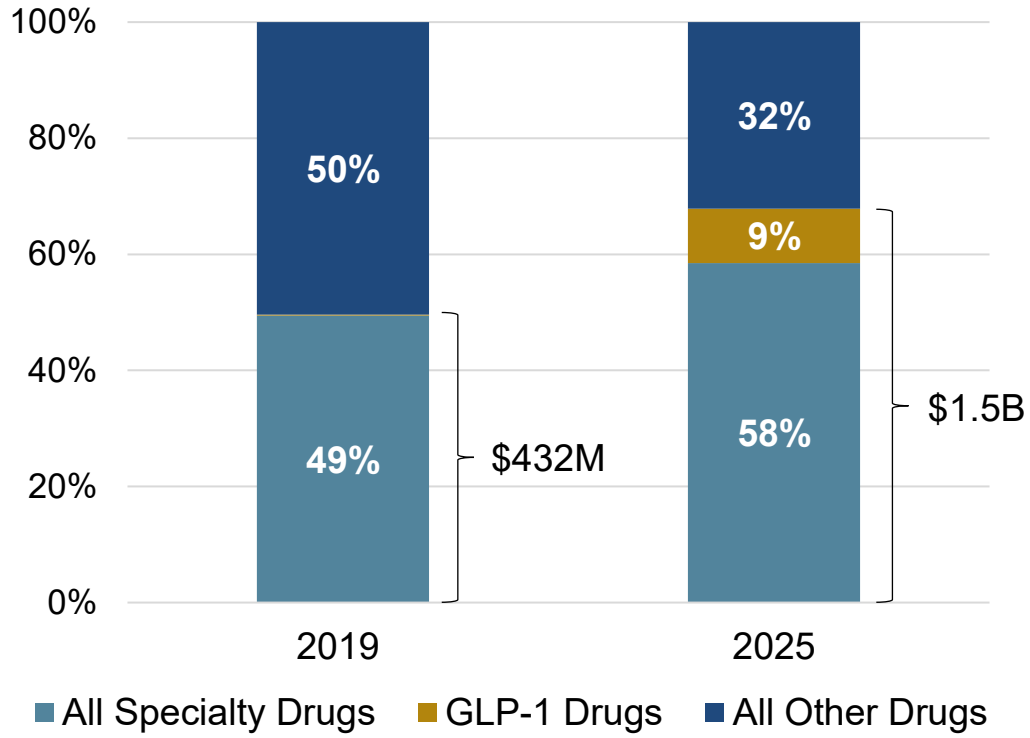
Notes: *Benchmark not available; ^Estimated benchmark is based on Fee-for-Service Medicaid Programs.

Source(s): Analysis of CMS State Drug Utilization Data; DHHS PHP Contract; KFF, "Recent Trends in Medicaid Outpatient Prescription Drugs and Spending," March 12, 2026. CMS, "Medicaid Managed Care Plan (MCP) FFY 2023 Drug Utilization Review (DUR) Annual Report." 2023. CMS, "Medicaid Fee-For-Service (FFS) FFY 2023 Drug Utilization Review (DUR) Annual Report," 2023. Myers and Stauffer, (NC) Pharmacy KPIs based on Key Statistics, Q1 SFY2026. Prime Therapeutics, "Medicaid Pharmacy Trend Report," 2025.

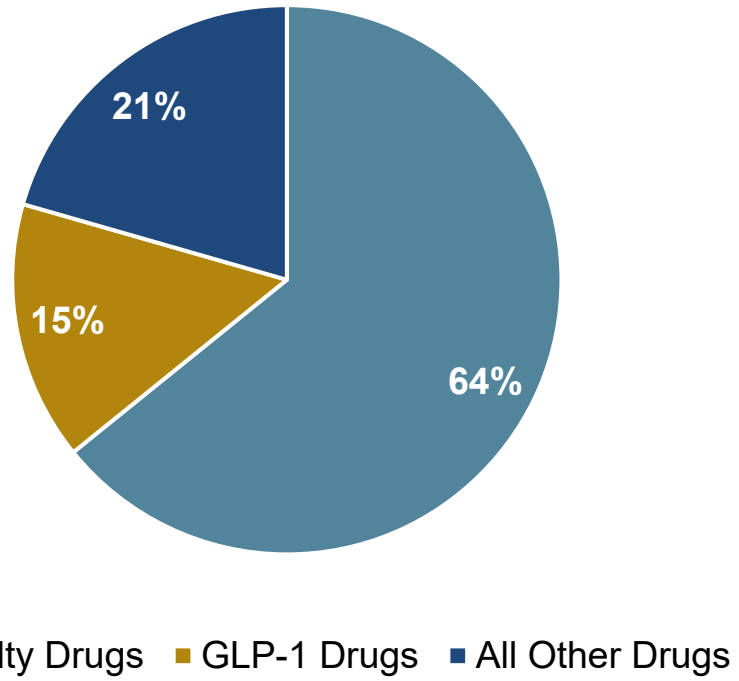
Total Specialty vs. Non-Specialty Drug Spending

Post-rebate spending on GLP-1s and specialty drugs more than tripled between 2019 and 2025, with these drugs accounting for nearly 80% of the growth in post rebate drug spending over this 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

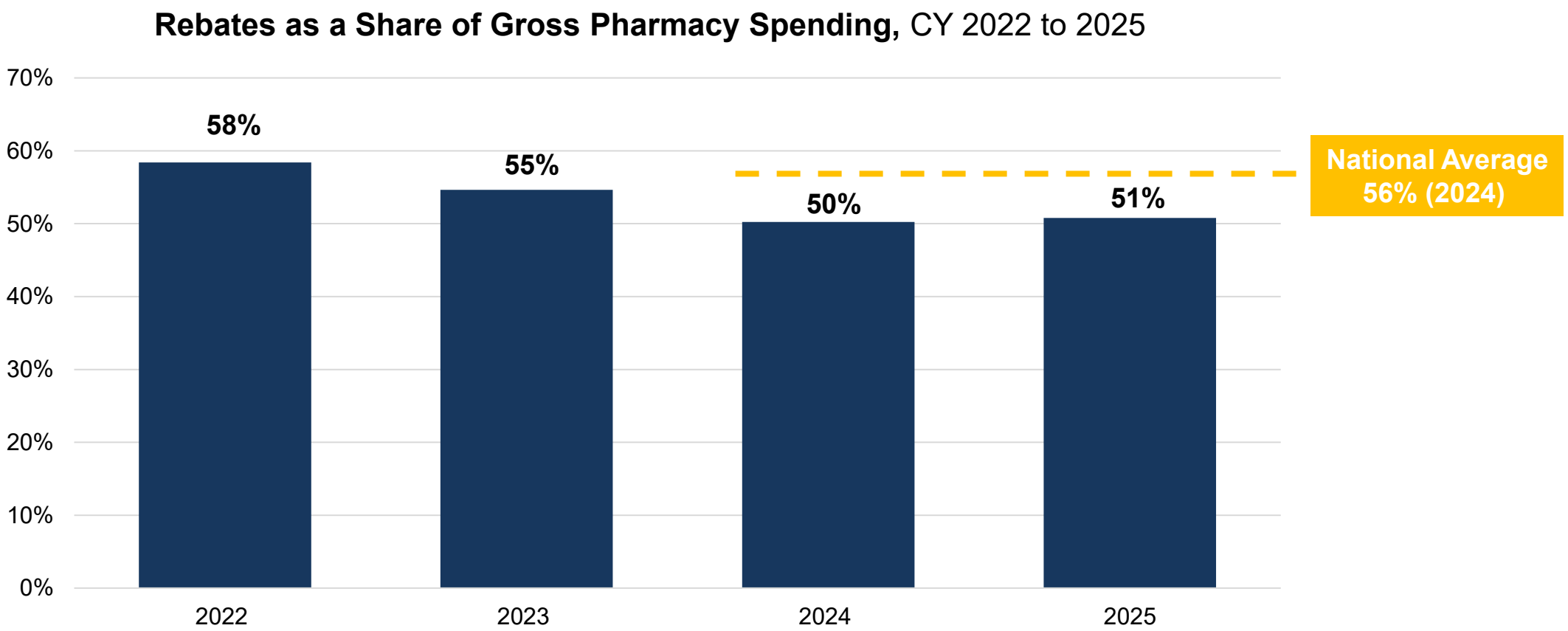


Notes: GLP-1 drugs are classified as non-specialty drugs for the purposes of this analysis.

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

Rebates as a Share of Gross Pharmacy Spending

Growth in North Carolina's prescription drug rebates has not kept pace with growth in overall drug spending, putting North Carolina below the national average of 56%.

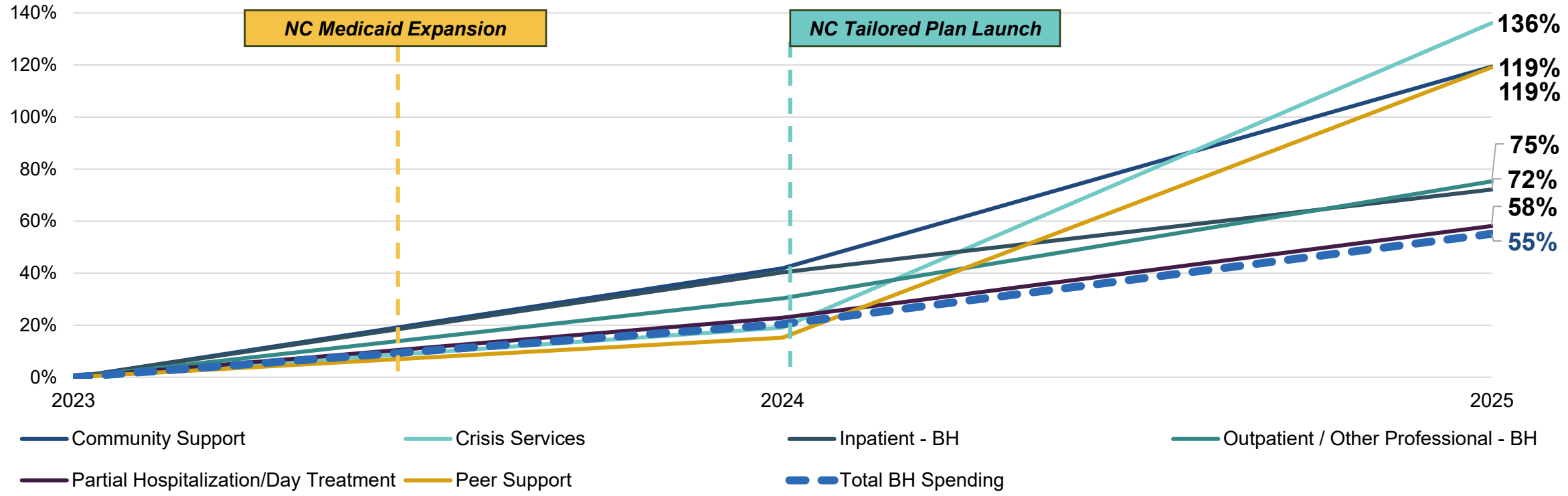


Source(s): Analysis of pre-rebate spending provided by Mercer and post-rebate spending and claims data provided by Prime Therapeutics; KFF, "Recent Trends in Medicaid Outpatient Prescription Drugs and Spending."

North Carolina Behavioral Health Cost Drivers

Per enrollee spending on behavioral health services has increased, particularly for crisis services, community support, and peer support services, where the state has made deliberate investments.

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



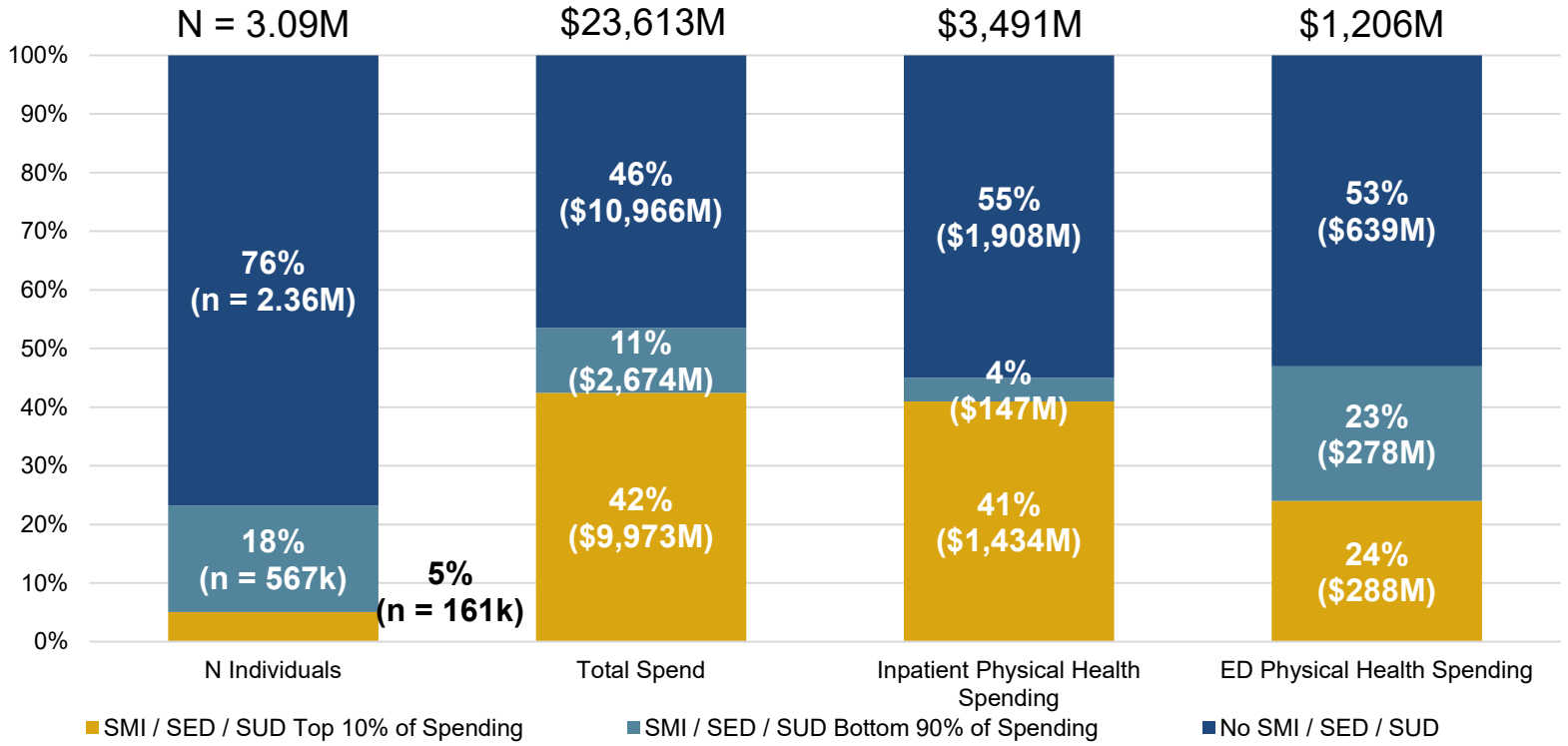
Notes: See Notes in Appendix.

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

Total Spending for Individuals with Mental Illness and SUD

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 spend
  - 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.

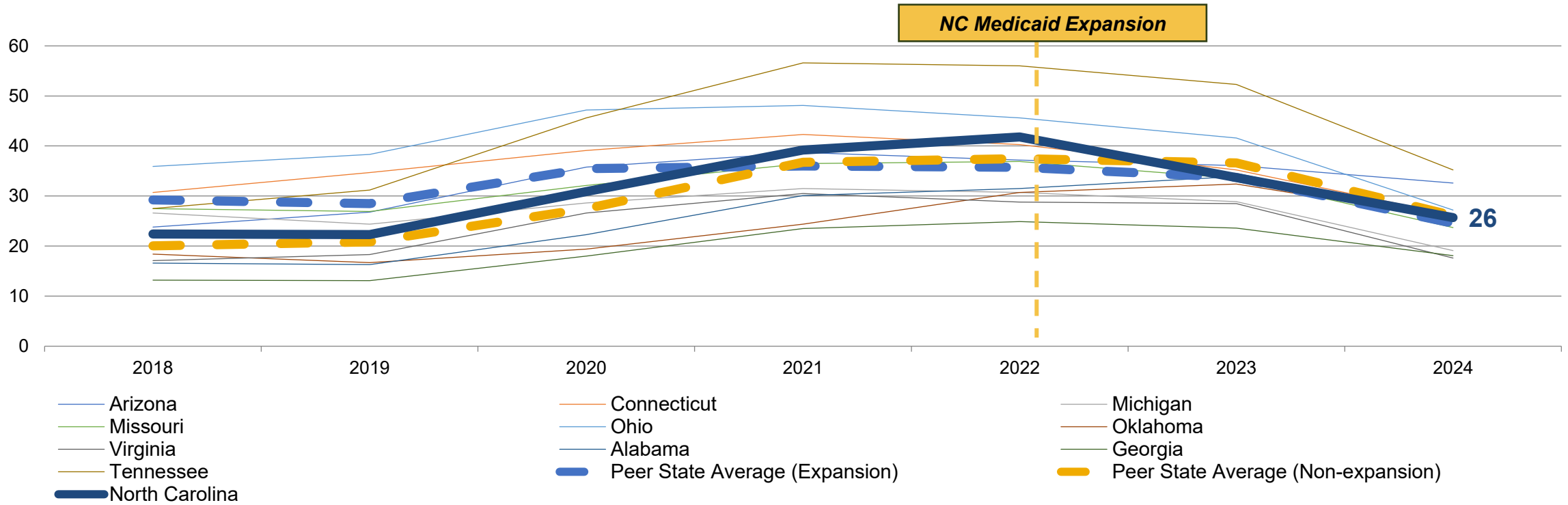
Notes: See Notes in Appendix.

Source: Analysis of Mercer provided data.

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 average trend.

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

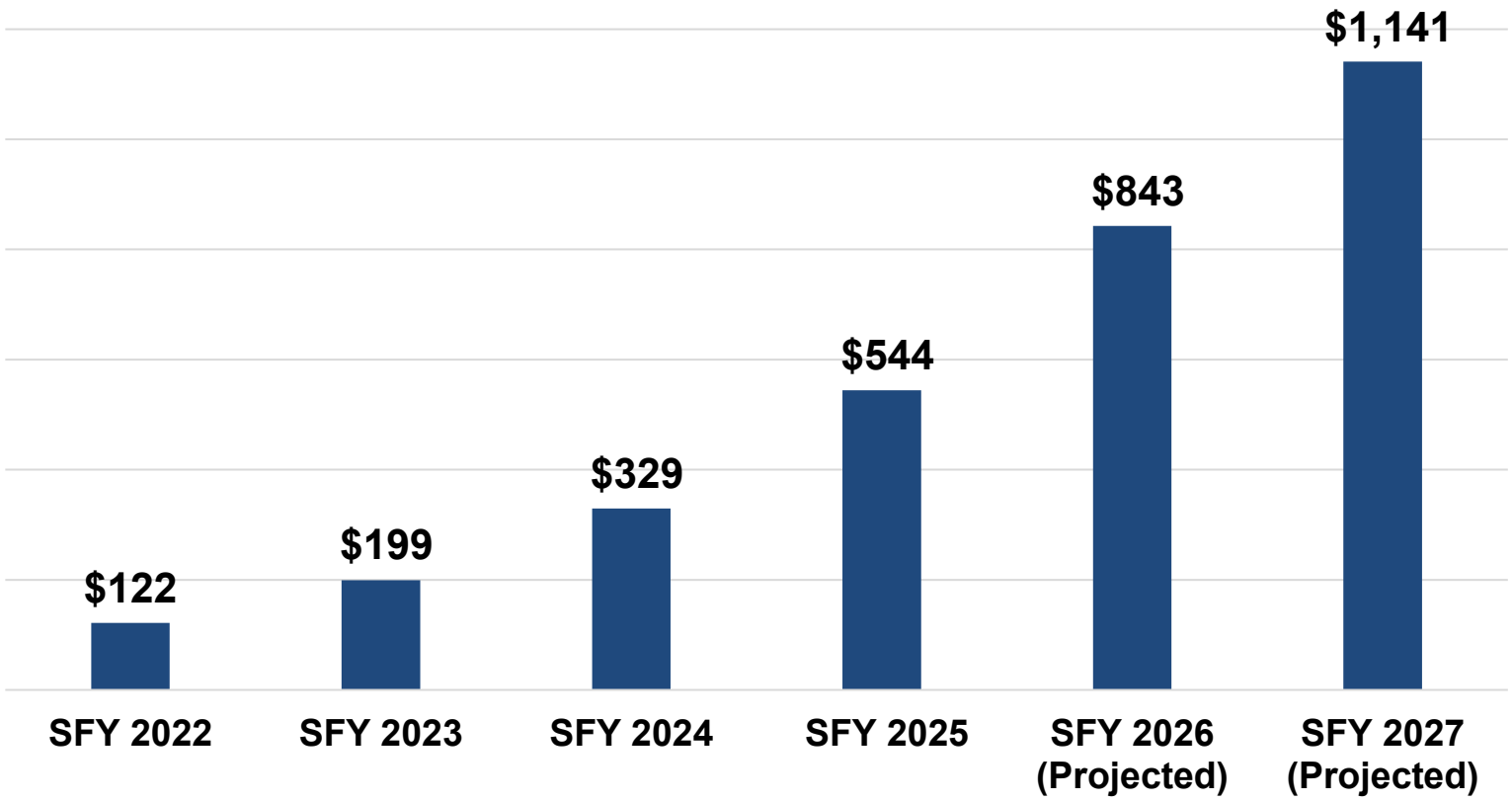


Source: Centers for Disease Control and Prevention, National Center for Health Statistics, "Multiple Cause of Death, 2018-2024." CDC WONDER Online Database.

Total North Carolina RB-BHT Spending Growth

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 to 2027 (in millions)



Key Considerations

- RB-BHT covers research-based treatment modalities for autism spectrum disorder that are "supported by credible scientific or clinical evidence."
- Since summer 2025, DHHS 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)

Estimated Cost Impact of Managed Care

While medical expenses are estimated to be lower for the managed care population, non-benefit load largely negates those savings.

Comparison of SFY 2024 Managed Care Costs to Estimated FFS Costs

Expense	Managed Care PMPMs	Estimated FFS Equivalent PMPM*	Total Cost of Managed Care vs. FFS (Est., PMPM)	Total Cost of Managed Care vs. FFS (Est.)
Total Medical	$335.40	$373.46	($38.06)	($829,400,000)
Non-Benefit Load**	$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**

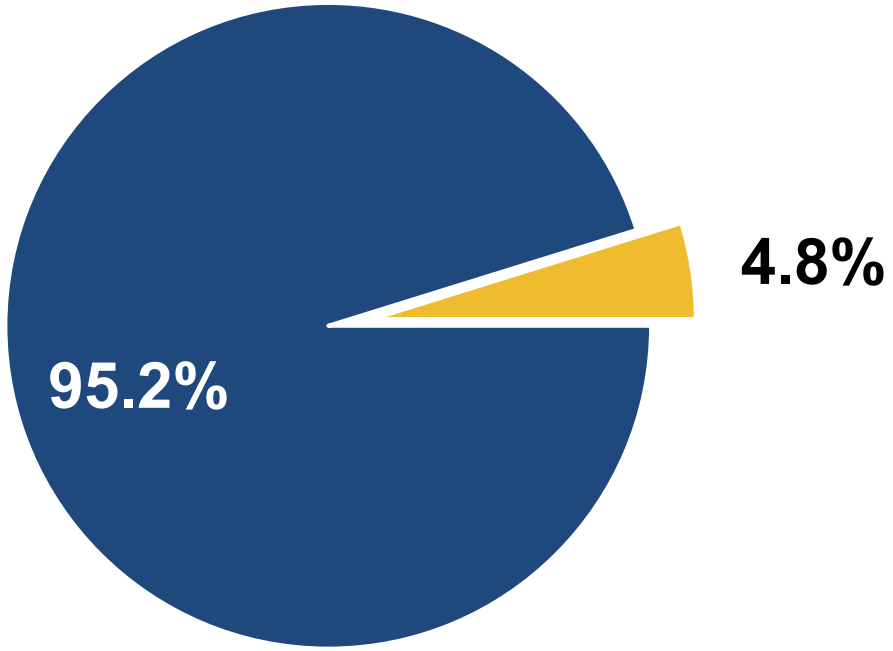
*FFS equivalent is a hypothetical projection of CY 2019 base data with relevant adjustments for trend and programmatic changes.
** Non-benefit load includes general admin expenses, care management, and underwriting gain.

Source(s): Analysis of Mercer 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.

Administrative Spending as a Share of Total Medicaid Spending

North Carolina spent $1.33 billion to administer its $27.6 billion Medicaid program - around 4.8% of total spending.

State Medicaid Administrative Spending as a Share of Total Medicaid Spending, FFY 2024



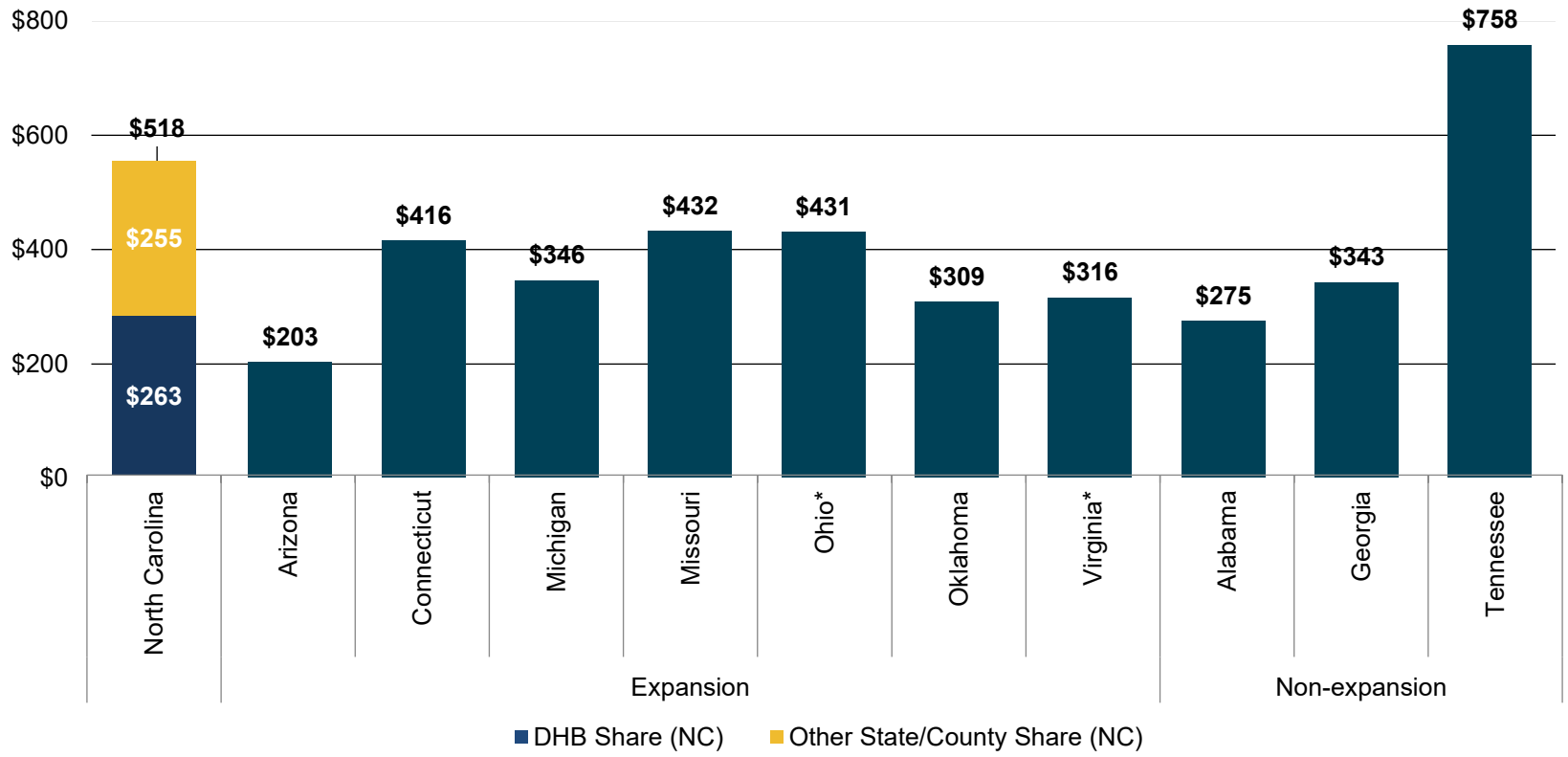
Notes: FFY = Federal Fiscal Year; Administrative share reflects CMS-64 net administrative expenditures ($1.3B, ADM tab) as a share of total-computable Medicaid spending ($27.6B), FFY 2024.

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

NC Medicaid Administrative Spending Per Enrollee

NC Medicaid's statewide administrative spending per enrollee is higher than most Peer States.

Medicaid Total Administrative Spending Per Enrollee, FFY 2024



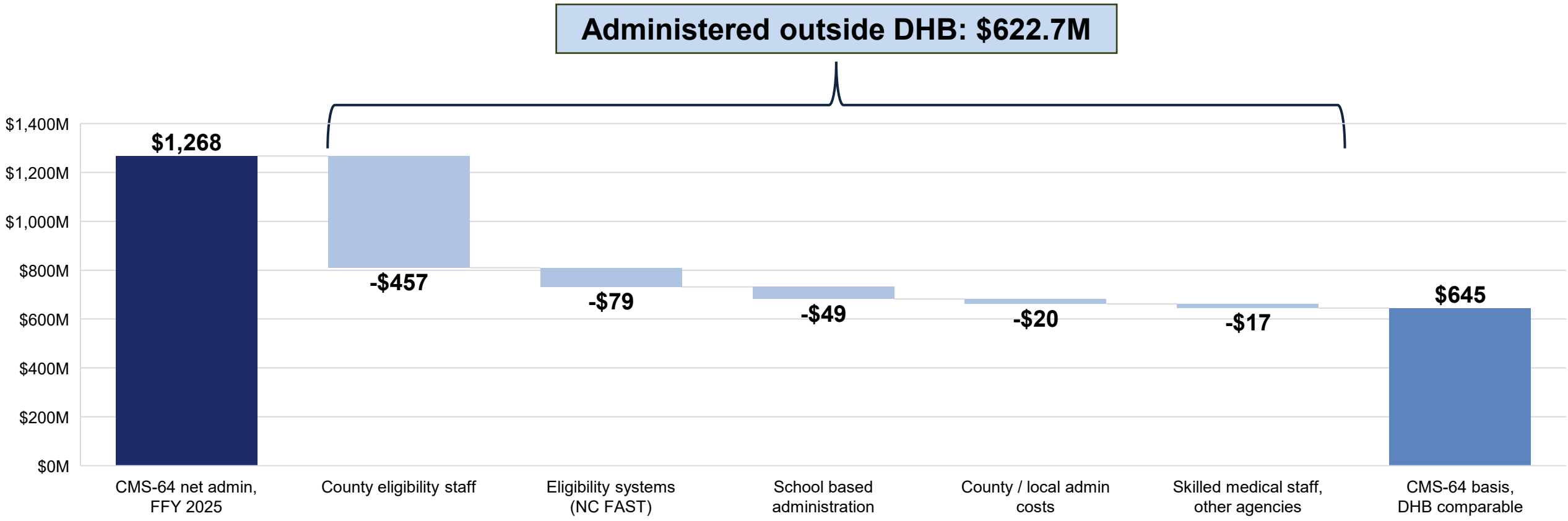
State	Per-Enrollee Total Admin Spend (FFY 2024)
Tennessee	$758
North Carolina	**$518**
Missouri	$432
Ohio	$431
Connecticut	$416
Michigan	$346
Georgia	$343
Virginia	$316
Oklahoma	$309
Alabama	$275
Arizona	$203

Notes: FFY = Federal Fiscal Year; See Notes in Appendix

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 Decomposition

Half of Medicaid administration spending resides outside of the Division of Health Benefits, including at the county level, where county eligibility staff accounted for $457 million of expenditures in FFY 2025.

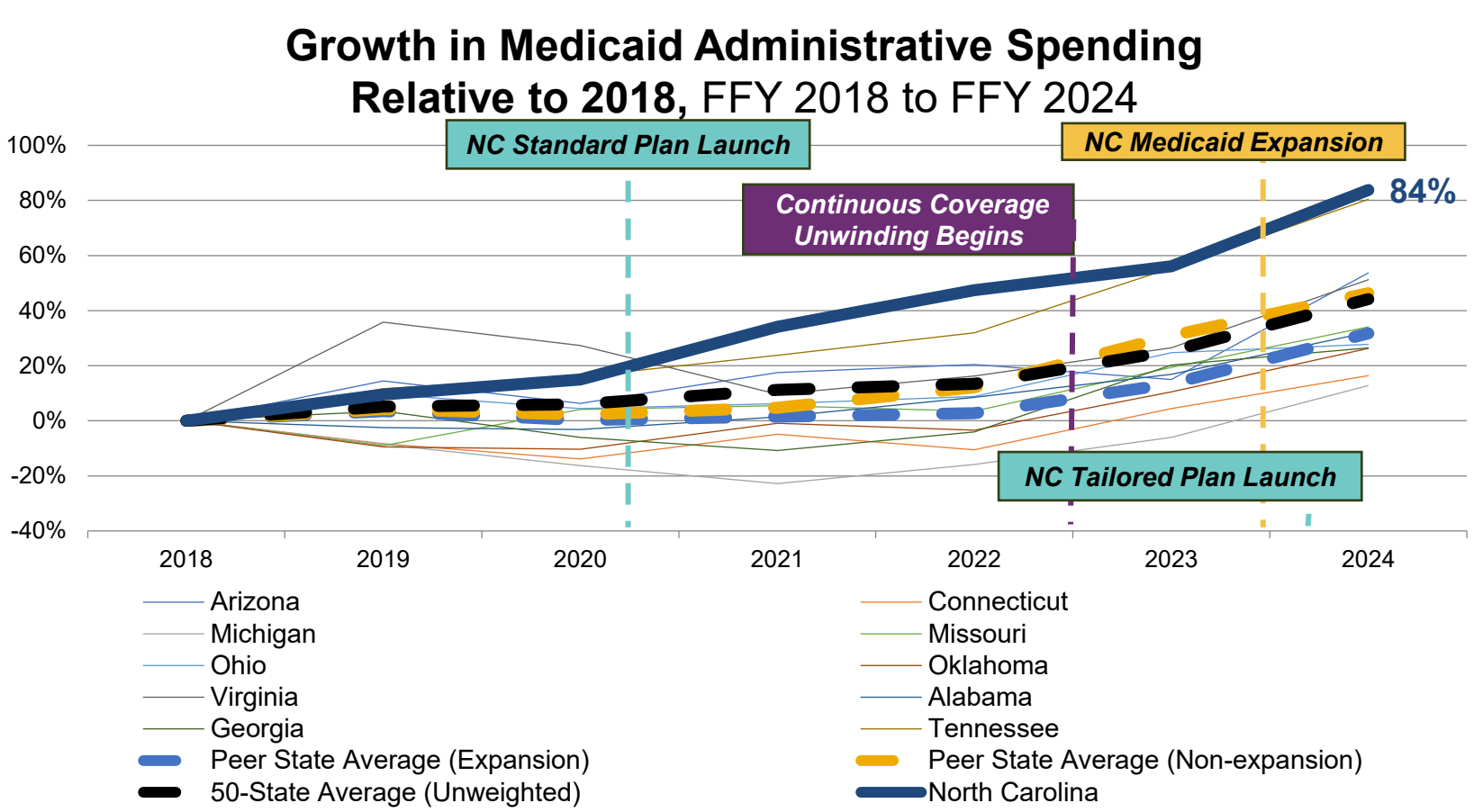


Notes: See Notes in Appendix.

Source: NCDHHS provided analysis.

Total NC Medicaid Administrative Spending Growth

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



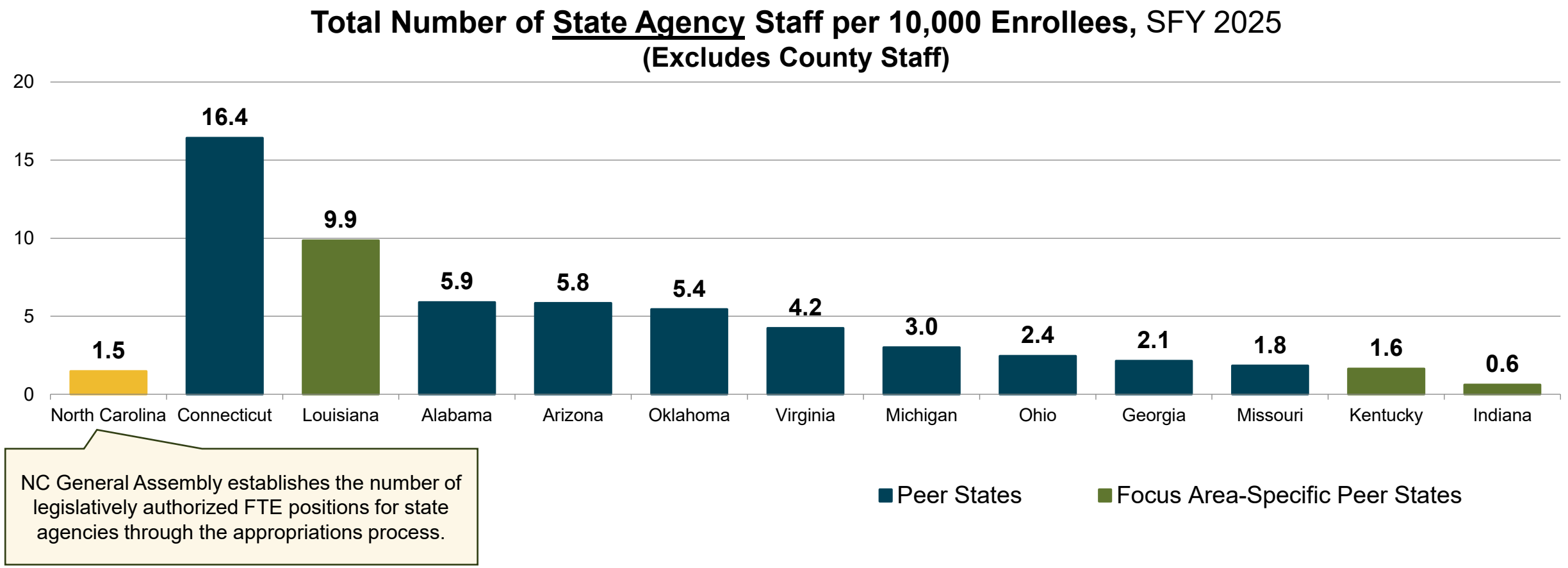
State	Administrative Service Spending	
	FFY 2024	Change (FFY18-24)
North Carolina	**$1,326,183,162**	**84%**
DHB*	$674,596,325	-
County/Other*	$651,586,837	-
Tennessee	$1,119,126,043	80%
Arizona	$421,844,720	54%
Virginia	$570,877,479	51%
Missouri	$553,664,414	34%
Alabama	$292,879,626	32%
Ohio	$1,215,044,711	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; See Notes in Appendix
*Values for North Carolina assume that approximately 51% of total administrative spend 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.

Medicaid Agency Staffing by State

North Carolina Medicaid has the fewest state agency staff per Medicaid enrollee than peer states.



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

Notes: See Notes in Appendix.

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

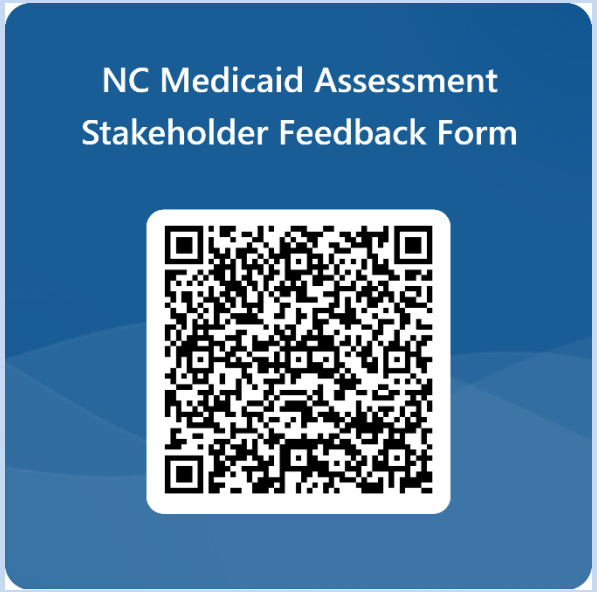
Opportunities for Stakeholder Engagement

Opportunities to Contribute to the Assessment

Upcoming Webinar & Opportunity for Feedback

Feedback Submission

Submit your feedback here:



Link: https://forms.cloud.microsoft/g/w7jhAdT4ZY

Next Webinar

- Our next webinar will focus on potential actions to address opportunities discussed today.
- **We plan to host this webinar in early October – stay tuned for more information!**

For additional information about the NC Medicaid Assessment, visit:
https://medicaid.ncdhhs.gov/assessment

Q&A

Thank you!

Appendix

Notes

Slide Title	Notes
Medicaid Not Immune From Health Care Cost Growth Pressures	Eligibility groups based on MACPAC approach for summing full year equivalent enrollees by eligibility group.
Medicaid as a Share of State General Revenue Spending by State	North Carolina expanded Medicaid in December 2023. Medicaid General Fund expenditures and State General Fund expenditures are self-reported by states to NASBO. Spending does not reflect administrative spending by the state or managed care plans. Peer state averages are unweighted.
North Carolina Medicaid Cost Growth Drivers	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. *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 beneficiary.
Medicaid Enrollment Growth in North Carolina	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.
Medicaid Enrollment and Uninsured Rates by State	North Carolina expanded Medicaid in December 2023. 2020 data are missing from the report due to COVID-19 disruptions to survey data collection. Uninsured values include individuals who have no evidence of other coverage or only Indian Health Services coverage. Peer state averages are unweighted;
Medicaid Total Spending per Enrollee by State	North Carolina expanded Medicaid in December 2023. Expenditures and enrollment values include Medicaid and M-CHIP, including federal and state shares. Annual enrollment counts are annual averages of monthly counts and may undercount unique individuals. Peer state averages are unweighted.

Notes

Slide Title	Notes
Growth In Total Medicaid Spending per Enrollee by State	North Carolina expanded Medicaid in December 2023. Expenditures and enrollment values include Medicaid and M-CHIP, including federal and state shares. Annual enrollment counts are annual averages of monthly counts and may undercount unique individuals. Spending reflects total computable spending. Spending does not reflect administrative spending by the state or managed care plans. Peer state averages are unweighted.
North Carolina Medicaid Cost Growth Drivers	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. *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 beneficiary.
NC Medicaid Hospital Spending Growth	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.
Institutional LTSS Spending Growth Per Enrollee by State	North Carolina expanded Medicaid in December 2023. Institutional LTSS includes hospice, ICF/IID, and nursing facility services. Long Term Community Supports (LTRDS) is treated as HCBS LTSS; prior to SFY 2024, it was classified as Institutional LTSS. Years reflected in UBDS data may reflect calendar or state fiscal years. 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

Notes

Slide Title	Notes
Community LTSS Spending Growth Per Enrollee by State	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 section 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.
LTSS Performance by State	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.
Per Enrollee Spending by Population Health Infrastructure Areas	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. 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.
Estimated Cost Impact of Managed Care	Medical savings includes All Other Services at $408.9 million ($18.77 PMPM), Hospital Services at $360.8 million ($16.56 PMPM), and Physician Services at $59.7 million ($2.74 PMPM). Across 72 peer-reviewed studies, managed care cost savings largely reflect utilization shifts to lower-cost settings rather than lower total program spending. However, there is no evidence that managed care reduces the total cost of Medicaid.
Total Spending for Individuals with Mental Illness and SUD	This slide includes individuals with a diagnosis of SED/SMI or SUD. 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.

Notes

Slide Title	Notes
North Carolina Behavioral Health Cost Drivers	Analysis begins in SFY 2023 because services were previously grouped into broader categories in Mercer 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 BH Long-Term Residential.
NC Medicaid Administrative Spending Decomposition	MBES Financial Management Report, net administrative expenditures, total computable, federal FY 2025 (certified; CMS has not yet published the FY25 FMR and later prior period adjustments may revise figures). Income statement: BD701 actuals, budget code 14445, state FY26. Cost allocation within the $410.0M and Other Financial Participation line pending working paper verification.
NC Medicaid Administrative Spending Per Enrollee	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. Values for North Carolina assume that approximately 51% of total administrative spend is attributable to DHB (corresponding to ‘CMS-64 basis, DHB comparable’ grouping on previous slide). States with an asterisk are other states using a county-based eligibility and enrollment model.
Total NC Medicaid Administrative Spending Growth	North Carolina expanded Medicaid in December 2023. Administrative spending includes expenditures related to state eligibility systems, MMIS, EHR incentive programs, and other administrative functions. 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
Medicaid Agency Staffing by State	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. Medicaid eligibility staffing models vary by state. While most states use state agency personnel, North Carolina (and seven 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, leading to less certainty in comparability.

Landscape Analysis Approach

The Landscape Analysis assessed North Carolina Medicaid and CHIP programs' cost drivers and outcomes over time and in relation to other state experiences to identify opportunities for enhancing value.

Approach

- **What We Asked**: What factors are driving outcomes, utilization, and spending trends across North Carolina's Medicaid program? How do these results compare to those of "Peer States"?
- **What We Did**: Engaged state Medicaid program subject matter experts to analyze and interpret data on program spending, utilization, and performance trends in aggregate and across eight "Focus Areas" to identify opportunities for program enhancement.
- **What Comes Next**: DHHS will share Landscape Analysis findings and Potential Actions with stakeholders for feedback.

Example Data Sources

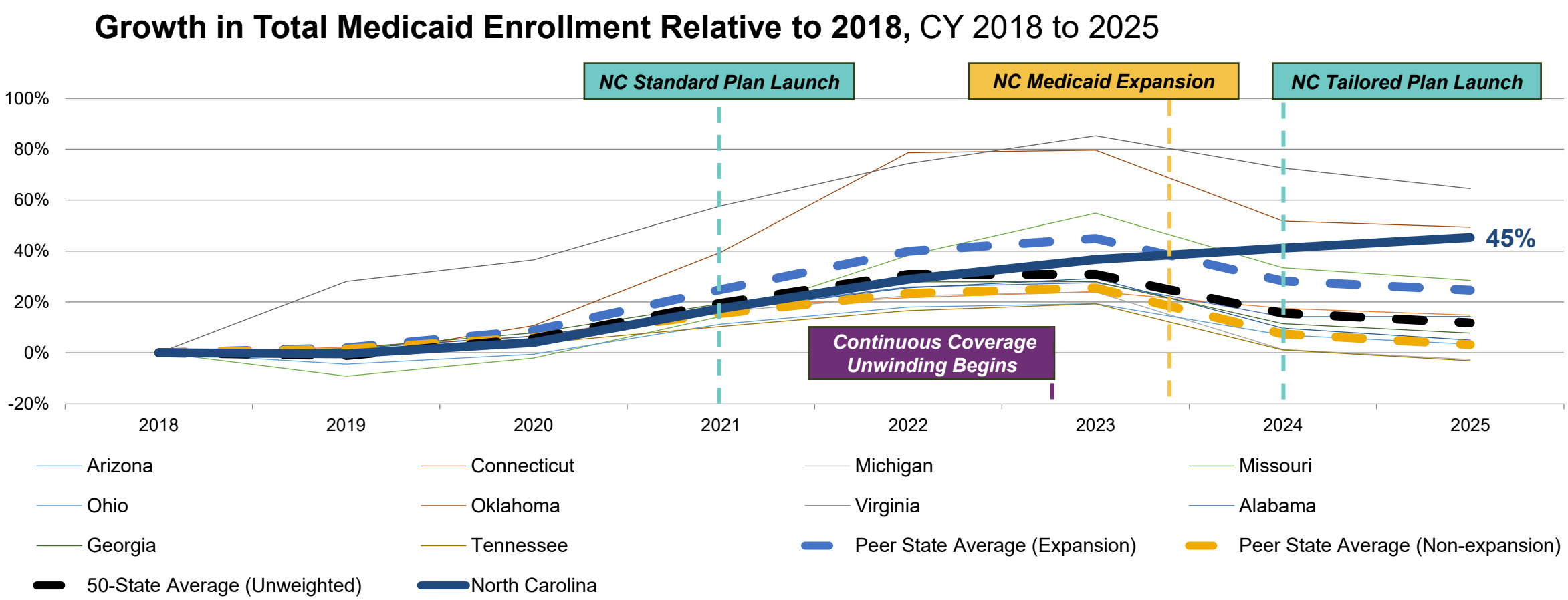
- CMS-64 Reports
- Universal Base Data Summaries (UBDS)
- CMS SDP Preprints
- CMS State Drug Utilization Data
- CMS Healthcare Provider Cost Reporting Information System (HCRIS)
- Adult and Child Core Set Quality Measures
- North Carolina Medicaid claims & encounter data

Available data sources subject to limitations including missing data for certain time periods and service categories

Notes: To enable cross-state benchmarking, analyses use publicly available data on total Medicaid program and service category costs, combining state and federal share expenditures.

Medicaid Enrollment by State

North Carolina's Medicaid enrollment trends were largely in-line with Peer States until 2023 as it implemented Medicaid Expansion.



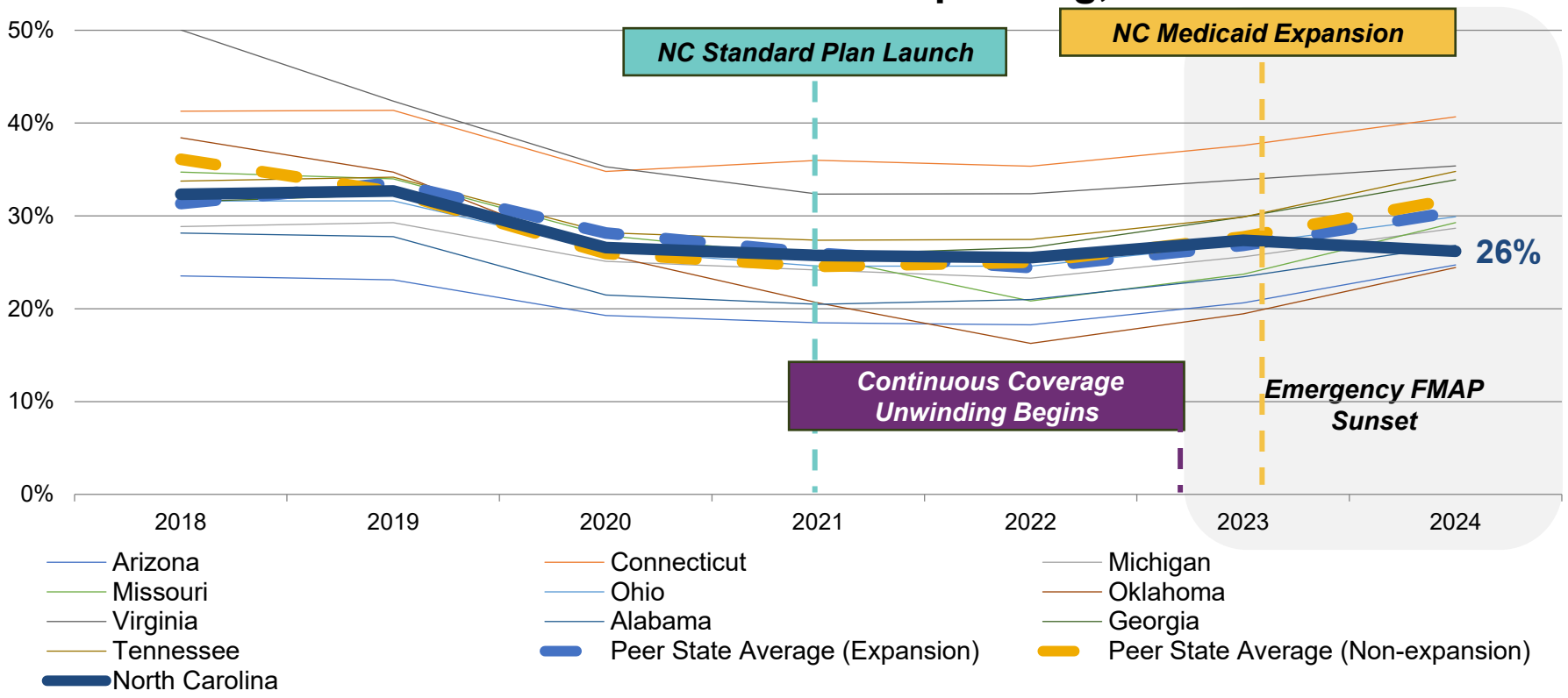
Notes: North Carolina expanded Medicaid in December 2023. Annual enrollment counts are annual averages of monthly counts and may undercount unique individuals. Enrollment counts do not include S-CHIP populations. Peer state averages are unweighted. CY = Calendar Year.

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

State Share of Medicaid Spending by State

North Carolina's state share of Medicaid spending decreased from 2023 to 2024 as the state's enhanced FMAP for its Expansion population offset the sunsetting of higher Emergency FMAP rates.

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.**

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.

Prioritized Focus Areas

The Landscape Analysis includes deep-dive analyses for high priority Focus Areas.

- Hospital Services
- Prescription Drugs
- Long-Term Services and Supports (LTSS)
- Behavioral Health
- Population Health and Primary Care
- Administrative Services
- Managed Care
- RB-BHT

Note: *Focus Areas were selected based on their anticipated contribution to total Medicaid spend; potential opportunities to improve value, efficiency, and outcomes; and availability of data required to support meaningful analyses. RB-BHT is not covered in detail in today's webinar.*

NC Hospital Payment Landscape Changed Significantly in Past Five Years

Since 2021, NC has made major structural changes to hospital payments in service of improving healthcare coverage and access to services. Some of these gains are at significant risk because of 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 SFY25, NC tied HASP payment levels to hospitals' participation in the state's groundbreaking 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 HASP SDP.

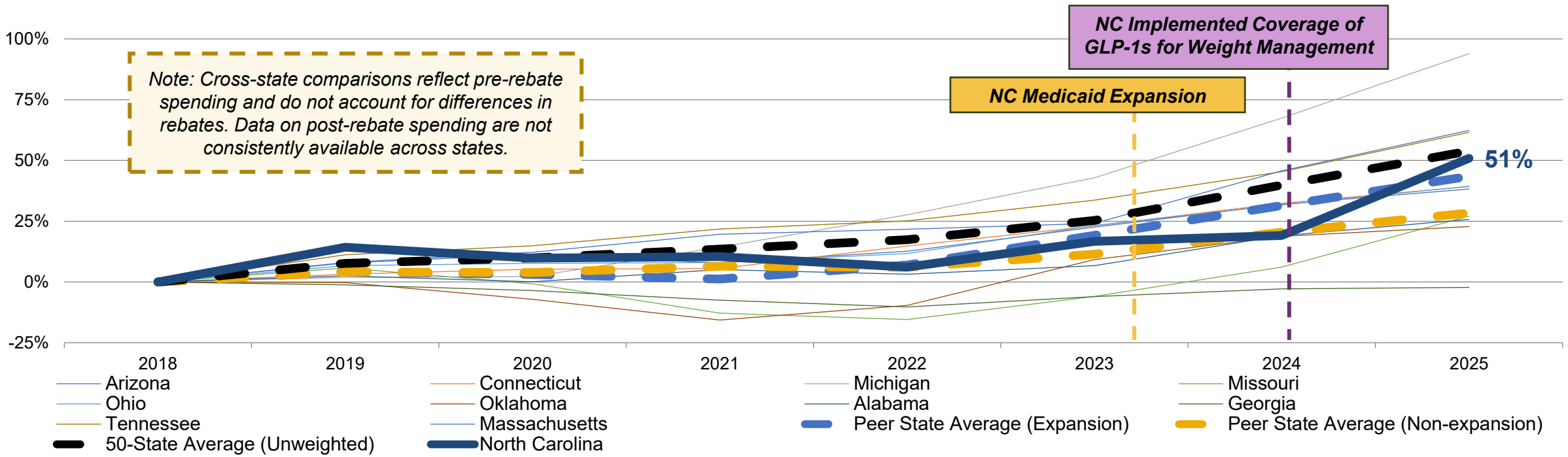
Jul 2025: H.R. 1 Enacted
H.R. 1 reduces the maximum allowable levels of SDPs and provider taxes. This will result in cuts to hospital payments and puts NC's Medicaid Expansion financing strategy at risk.

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

Pre-Rebate Prescription Drug Spending per Enrollee by State

North Carolina's growth in pre-rebate drug spending per enrollee tracked near the Peer Expansion State average from 2018 to 2024 before increasing in 2025.

Growth in Pre-Rebate Medicaid Drug Spending per 1,000 Person-Months Relative to 2018, CY 2018 to 2025

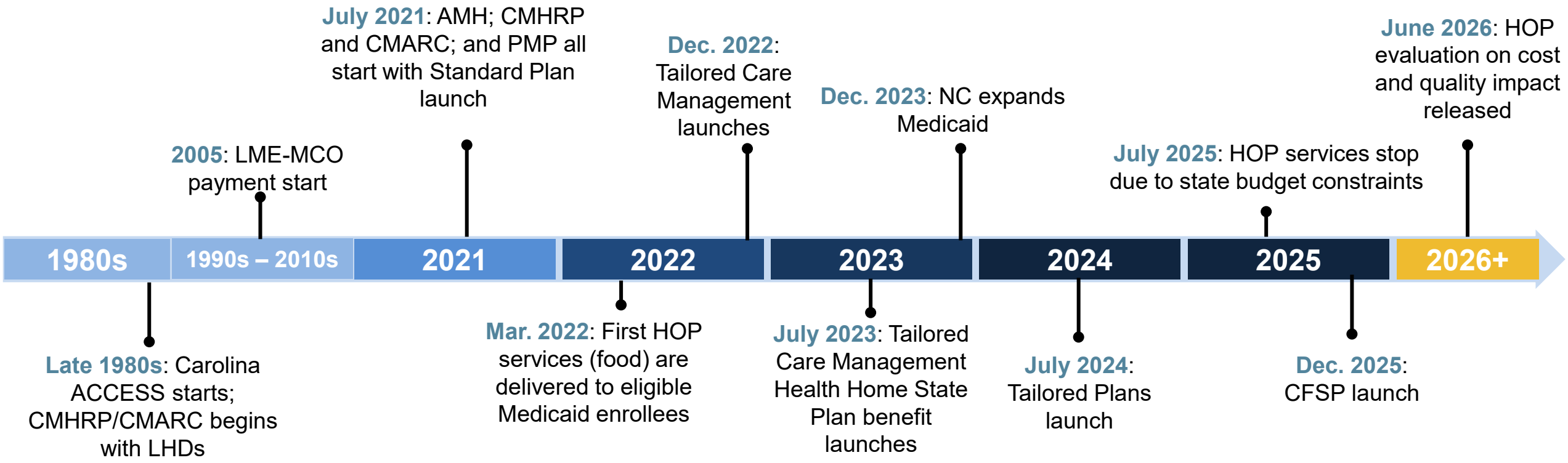


Notes: Trends described here reflect pre-rebate drug spending. Trends in post-rebate drug spending may differ from trends in pre-rebate spending. North Carolina expanded Medicaid in December 2023. The State Drug Utilization data contains state-submitted information on drug prescription, rebates, and 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. GLP-1 drugs are classified as non-specialty drugs in NC Medicaid. CY = Calendar Year. Person-months enrolled are used as the denominator and are sourced from the CMS Medicaid and CHIP Eligibility Operations and Enrollment Snapshot, which reports monthly state-level Medicaid and CHIP enrollment. Massachusetts has been added to this analysis at the State's request given its coverage of GLP-1s for weight management. Massachusetts is not part of the defined Peer State group and is excluded from Peer State averages.

Source: Analysis of CMS State Drug Utilization Data

Population Health Changes & Trends

North Carolina's Population Health infrastructure has transformed over time.

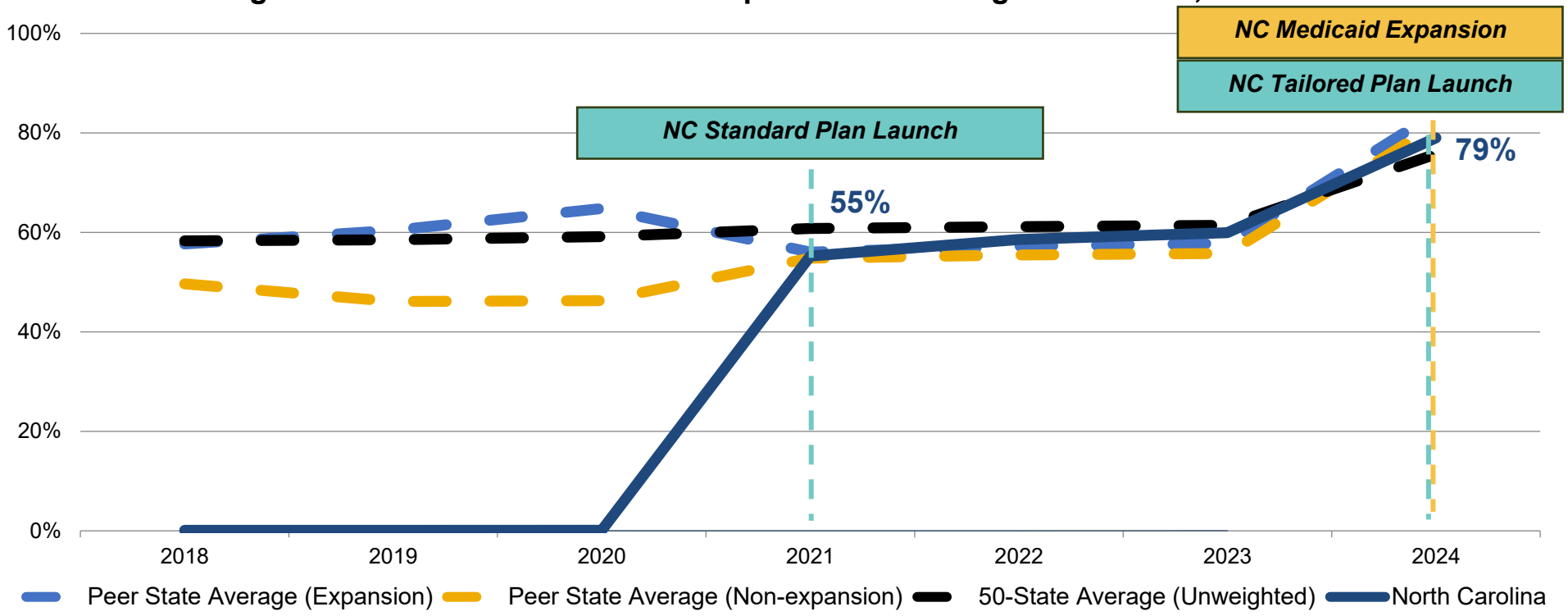


Context: North Carolina's Shift to Managed Care

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.

- 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 four plans.
  - **Child and 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

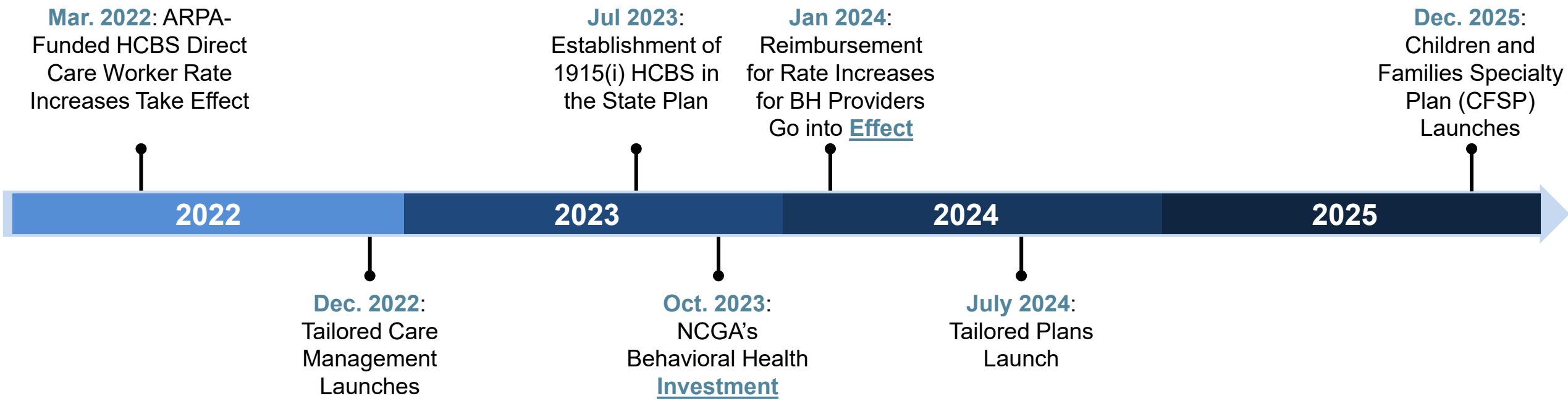


Notes: Data quality of the TAF can vary by state. TAF data are subject to state specific limitations; see the TAF Data Quality Atlas for additional details. Further information on data quality can be found in the DQ Atlas. Peer state averages are unweighted; FFY=Federal Fiscal Year; FFS=Fee-for-Service. 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.

Behavioral Health Infrastructure Changes & Trends

From 2022 to 2025, North Carolina expanded access to and quality of Medicaid behavioral health, from workforce, Tailored Care Management, and HCBS investments to the Tailored Plans and CFSP launch, advancing managed care and support for North Carolinians with specialized behavioral health needs.



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

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