JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID

NC Department of Health and Human Services

Medicaid Enrollment & Financial Update

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Who is enrolled in Medicaid?

1 out of every **4** North Carolinians

2 out of every **5** children in North Carolina

3 in **10** people with disabilities in North Carolina

5 in **8** people in nursing facilities

Who is eligible for Medicaid by Group or Condition?

Non-expansion

(Medicaid rebase)

Adults aged 65 and older

People experiencing blindness or physical or intellectual/developmental disabilities

People dually eligible for Medicare

Individuals with Traumatic Brain Injuries

Pregnant women

Parent/caretakers below 42% FPL

Children from birth to age 21

Foster children, Former Foster Children, and Special Needs Adoptees

People with Breast and Cervical Cancer

People receiving limited Family Planning benefit

Expansion

(Hospital assessments)

Adults aged 19-64 with incomes below 138% FPL

For more details see: https://policies.ncdhhs.gov/wp-content/uploads/Basic-Medicaid-Eligibility-9.pdf

Who is eligible for Medicaid by Income?

Non-expansion

(Medicaid Rebase)

Annual Income by Family Size

Age 65; Blind; Disabilities

100% Poverty Level

1 - $15,060

2- $20,448

Children 0-18

211% Poverty Level

1 - $31,788

2 - $43,140

3 - $54,492

Parent/Caretakers

42% Poverty Level

2 - $6,828

3 - $8,004

Pregnant Women

196% Poverty Level

1 - $29,520

2 - $40,068

3 - $50,616

Expansion

(Hospital Assessments)

Annual Income by Family Size

Adults aged 19-64

133% Poverty Level

1 - $20,040

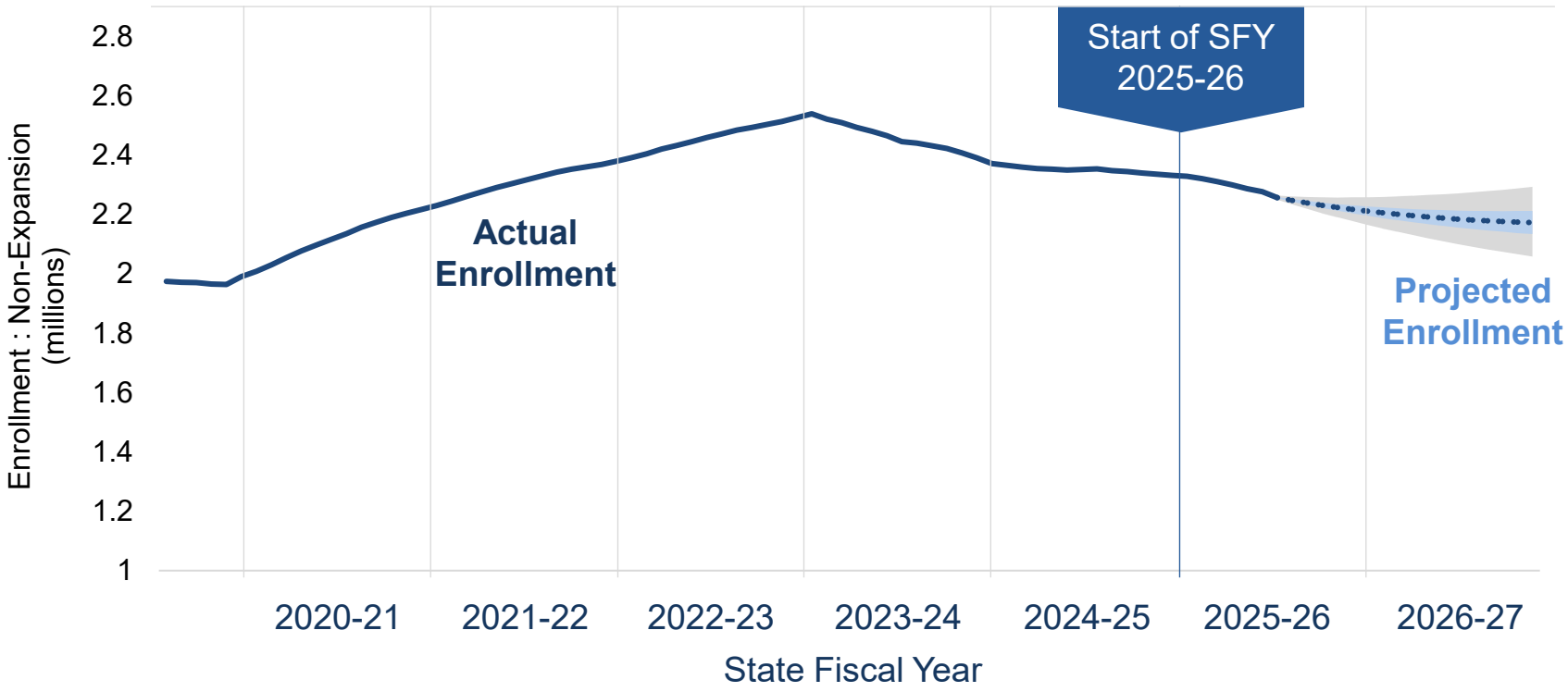
2 - $26,712

3 - $34,344

For more details see: https://policies.ncdhhs.gov/wp-content/uploads/Basic-Medicaid-Eligibility-9.pdf

Medicaid Non-Expansion Enrollment Trends

Enrollment continues its planned normalization following the pandemic-era continuous coverage requirements, tracking closely with consensus projections.



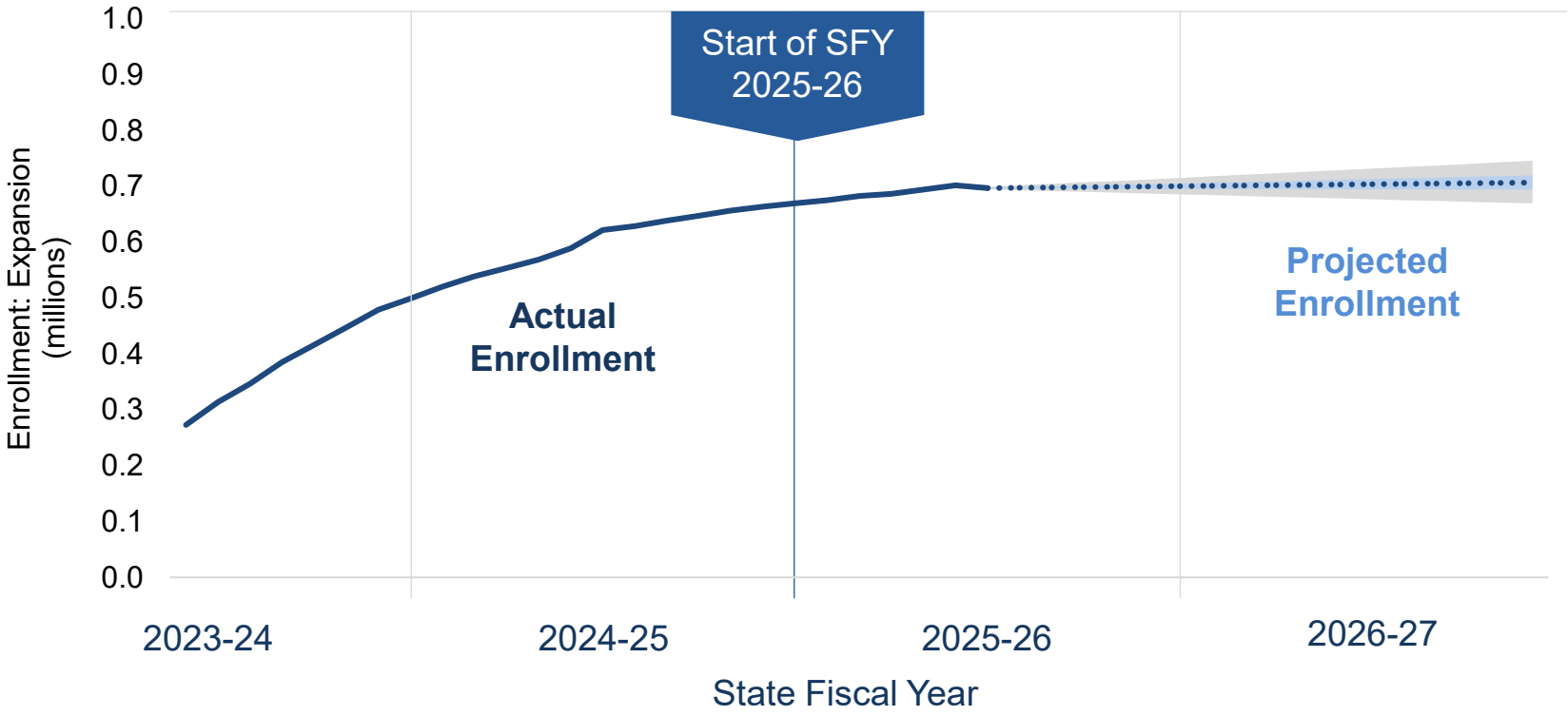
* Values from January 2026 on are projected and do not represent actual enrollment.

** Shaded areas represent +/- 0.1% (**blue**) and +/- 0.3% (**gray**) monthly deviation from consensus forecast

Source: DHB-OSBM census forecast, February 2026.

Medicaid Expansion Enrollment Trends

Expansion enrollment has reached a stable plateau, with future growth projected to remain consistent and predictable



No State General Fund dollars are used to pay for Medicaid Expansion

* Values from January 2026 on are projected and do not represent actual enrollment.

** Shaded areas represent +/- 0.1% (**blue**) and +/- 0.3% (**gray**) monthly deviation from consensus forecast

Source: DHB-OSBM census forecast, February 2026.

Medicaid Rebase: A Data-Driven Budget Alignment

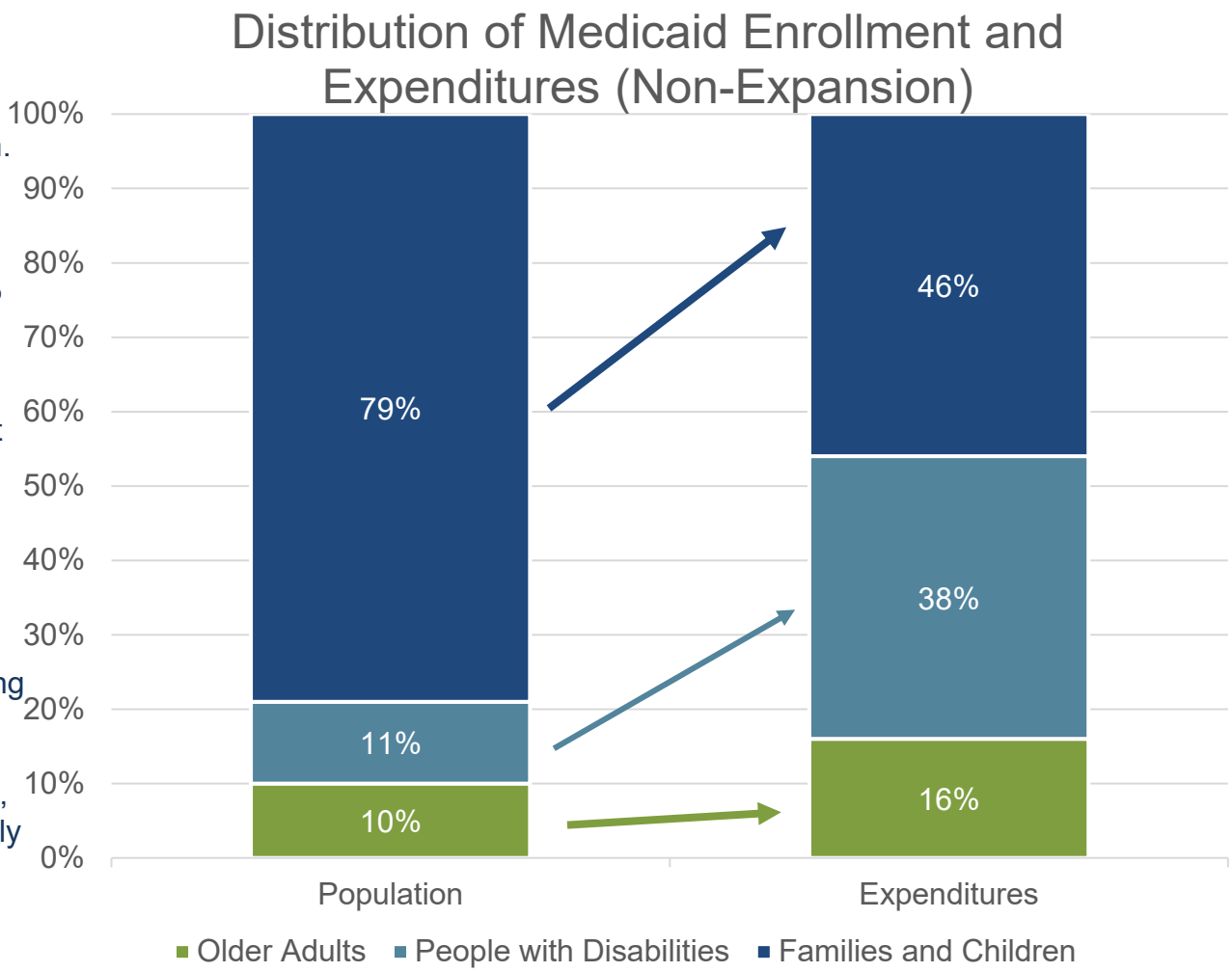
Funding Rebase ensures that the budget accurately reflects changes for the upcoming fiscal year. Over time, aspects of the Medicaid program change, including enrollment, service utilization and costs, and the per-person rates paid to health plans

- **Goal:** adjusting the budget to **ensure adequate funding for the existing program for the non-expansion population**. Rebase funds the per-person (or 'capitation') rates paid to the managed care plans that administer the program.
- **Drivers:** accounts for critical variables that shift year-over-year:
  - **Enrollment:** changes in the number of members enrolled.
  - **Utilization:** shifts in the types and frequency of healthcare services used.
  - **Inflation:** general healthcare cost increases.

This is a joint annual effort between Office of State Budget and Management (OSBM), Fiscal Research Division (FRD), and Division of Health Benefits (DHB)

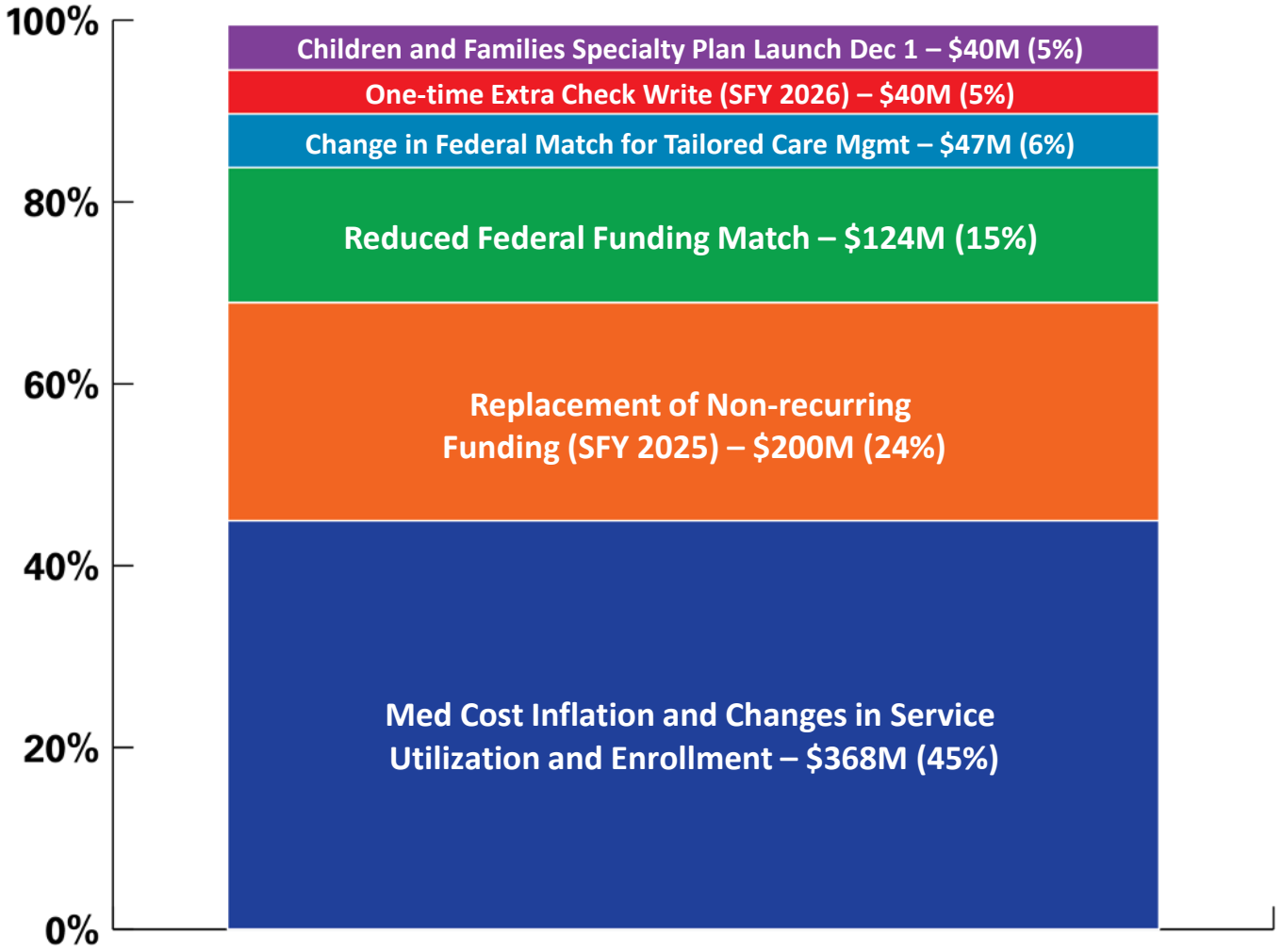
Enrollment vs. Expenditure Drivers

- **Families and Children:** Represent **79% of enrollment** but **46% of total expenditures**. This remains the most cost-effective segment of the program.
- **High-Acuity Care:** Older adults and people with disabilities account for **21% of enrollment** but drive **54% of Medicaid spending**.
- **Targeted Stewardship:** Medicaid serves as a critical financial safety net for long-term care and disability services, which are inherently more resource-intensive than standard primary care in commercial plans.
- **Sustainable Care Management:** Stewardship efforts focus on enhancing care coordination for high-acuity populations. By optimizing service delivery for those with complex needs, we ensure the program remains fiscally viable for all North Carolinians.



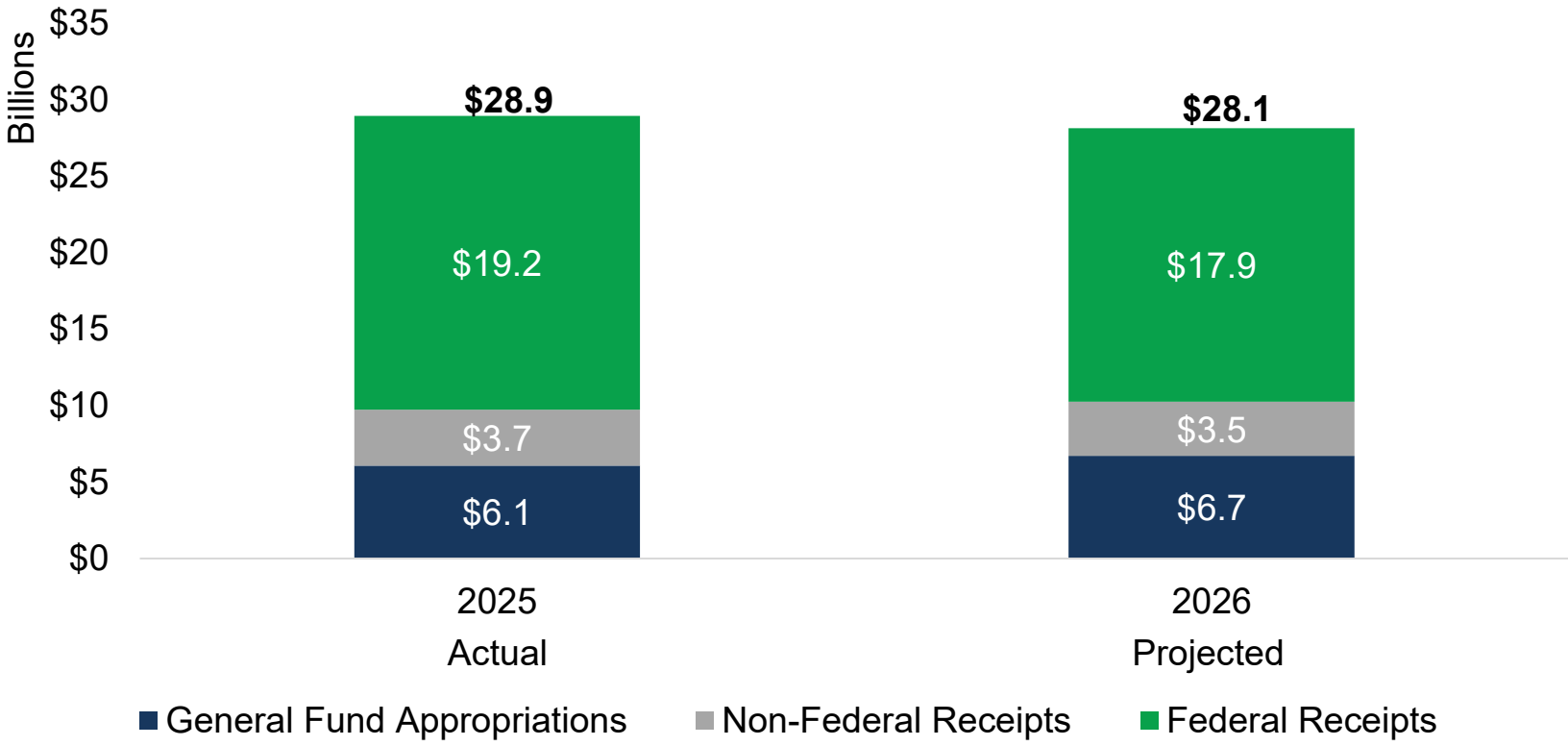
Composition of the Medicaid Rebase Need

The current funding requirement is driven by a combination of scheduled service expansions, shifting federal match rates, and standard healthcare inflation.



Medicaid Funding Outlook: FY25-26

While total program costs are projected to decrease in FY26, State funding requirements are rising due to shifting federal match rates and increased member utilization



Source: DHB-OSM consensus budget forecast, May 2025; NCFS

Meeting the Critical Funding Need: $319 Million

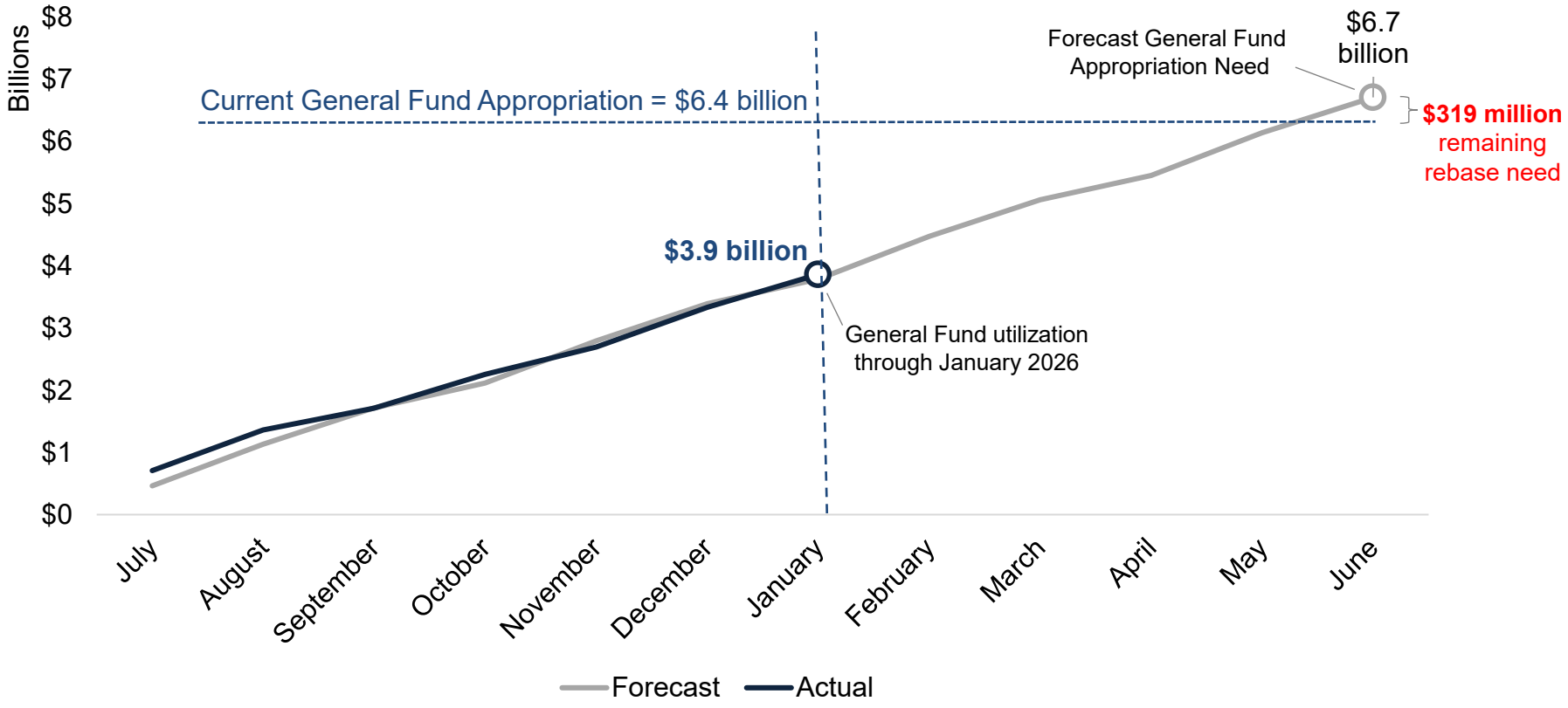
- **Current Status:** $319 million in State appropriations is required to fully fund NC Medicaid through the end of the current fiscal year
- **Budget Management:** Actual spending remains fully aligned with the NCDHHS projections established last year, reflecting accurate forecasting
- **Operational Risk:** Without legislative action, existing funds are projected to be exhausted prior to fiscal year-end, impacting program stability

NC Medicaid Serves 1 in 4 North Carolinians

Medicaid provides essential healthcare coverage for over **3 million residents**, including children, seniors, individuals with disabilities, and working families.

Fiscal Year 2026 Budget Performance

Utilization of state general fund appropriations continues to track precisely with consensus forecasts, confirming the accuracy of program modeling.



Source: DHB-OSM consensus budget forecast, May 2025; NCFS

Medicaid Fiscal Stewardship - NCSL

Medicaid Cost Drivers

NCSL Resources:
- Snapshot: Balancing State Medicaid Budgets
- *Upcoming December 2025: NCSL Report on Balancing State Medicaid Budgets*

Enrollment & Acuity

Service Type and Use

Provider payments

Administrative Costs

Federal-State Financing Dynamics & Economic Conditions

NCSL

Balancing Medicaid Budgets

State Policy Options

Contract Program Size	Improve Outcomes	Oversight and Evaluation	Identify Cost Drivers	Maximize Revenue
• Maximize Economic Mobility and Private Coverage • Restrict Eligibility • Restrict Benefits • Reduce Payment Rates	• Value-Based Care • High-Value Benefits • Population Health	• Program Integrity • Managed Care Oversight • Vendor Oversight	• Cost Commissions, Studies, Task Forces • All Payer Claims Databases • Consensus Budgeting, Forecasting	• Increase State Revenue • Provider Taxes* & Local Share • Leverage Enhanced Federal Match Rates

* The 2025 Budget Reconciliation Bill limits state uses of provider taxes. States may still create provider taxes but would have to comply with hold harmless requirements, which will limit use for supplemental payments and create higher risk of federal recoupment. Scope of permissible state use of provider taxes within hold harmless unclear.

NCSL CELEBRATING 50 YEARS

Avenues for Strategic Cost Management

1

Cost Avoidance

Annual capitation rates paid to managed care plans account for these ongoing cost avoidance strategies

- **Managed Care Optimization**
- **Pharmaceutical Cost Control**
- **Program Integrity & Modernization**
- **Clinical Initiatives**

2

Targeted Intervention

Adjustments that yield discrete savings over a shorter time period

- **Operational Efficiencies**
- **Enhanced Third Party Liability Recoveries**
- **Network Optimization**
- **Strategic Payment Optimization**
- **Changes to rates, services, and eligibility**

3

Long Term Strategies

Strategies that can yield savings over time, often indirect and only achievable with some upfront investment

- **Value-Based Infrastructure**
- **Managed Care Plan Optimization**
- **Fiscal Reinvestment**
- **Accountability & Innovation**

1. Cost Avoidance

- **Managed Care Optimization**
  - Refining capitation rates to drive plan efficiency
  - Improving accountability with performance-based withholds and Medical Loss Ratio (MLR) standards
- **Pharmaceutical Cost Control**
  - Accelerating Preferred Drug List (PDL) updates to a quarterly cycle
  - Implementing innovative value-based models for high-cost cell and gene therapies
  - Utilizing biosimilars when most cost effective for the State*
  - Achieved **$2.3 billion (total federal/State) in cost avoidance in FY25** through direct manufacturer negotiations
- **Program Integrity & Modernization**
  - Enhancing fraud, waste, and abuse detection and recovery efforts
  - Improving county eligibility accuracy through automation and streamlining
- **Clinical Initiatives**
  - Expanding value-based purchasing (VBP) across population health programs
  - Strengthening the inpatient readmission policy from 7 to 30 days to improve discharge planning and outcomes*
  - Revised skilled nursing facility admission criteria*

2. Targeted Interventions

- **Operational Efficiency:** Due to reductions in the NC Medicaid administrative budget this fiscal year, NCDHHS made **$139 million** in total contract reductions ($57 million in State funds) through vendor management and scope refinement, including delaying or stopping implementation of projects and oversight

Strategic Partner / Contract	Purpose	Total Reduction (millions)	State Funds (millions)
Accenture	Project management, program implementation, systems testing	$60.0	$30.0
General Dynamics IT	Claims payment, capitation payment, prior authorization, provider call center	$41.0	$11.0
Area Health Education Centers	Technical subject matter expertise, technical assistance	$14.0	$7.0
Manatt / IBM / Maximus	Program design, data analytics, enrollment broker	$22.0	$8.0
Other Partnerships (HR/Clinical)	Contracting consultants	$2.0	$1.0
Total FY26 Impact		**$139.0**	**$57.0**

2. Targeted Interventions

- **Enhanced Third-Party Liability (TPL) Recoveries**
  - Projected **$40 million** in "Come Behind" savings for SFY 25-26
  - Ensures Medicaid remains the payer of last resort by aggressively identifying primary insurance coverage

- **Strategic Payment Optimization (FY27)**
  - Will achieve **$8 million** in savings by accelerating non-expansion capitation payments by one week
  - This technical adjustment allows the State to leverage a more favorable federal medical assistance percentage (FMAP) before the rate step-down

- **Network Optimization**
  - Provides plans additional utilization management and network oversight tools to manage mental health parity requirements *

3. Long Term Strategies for Consideration

- **Value-Based Infrastructure:** Directing investments toward rural primary care, other site optimization, and value-based care initiatives to address the underlying drivers of health
  - Optimize the role of the care manager*
- **Managed Care Plan Optimization:** Future reprocurement of managed care contracts provide opportunities for a rational redesign.
- **Fiscal Reinvestment:** Premium tax revenue generated by Medicaid could be reinvested directly into Medicaid program sustainability
- **Accountability & Innovation:**
  - Implementing additional rigorous plan performance standards (e.g., medical loss ratios and withholds)
  - Leveraging **Artificial Intelligence (AI)** and advanced analytics for enhanced program oversight

NC Medicaid Capitation Rate Growth is Slower than National Average

- **North Carolina Medicaid's Standard Plan capitation rates have been growing 1.7% less per year than national trends on average over the last four years**

Source	2023	2024	2025	2026	Average Annual Increase
Standard Plan Non-Expansion Rate	2.9%	6.8%	6.5%	3.8%	5.0%
National Health Expenditure Per Enrollee trends from the CMS Office of the Actuary	5.2%	10.2%	5.8%	5.8%	6.7%

Source: Mercer