

POLICY FORUM: ISSUE BRIEF

Where We Are, Where We Are Going: North Carolina Medicaid in 2025

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The last decade has brought significant changes to NC Medicaid, including expansion, transformation, and recent federal policies. This issue brief assesses current coverage, access challenges, and future uncertainties, laying out the commentaries in the December 2025 issue of the North Carolina Medical Journal.

Introduction

There have been many “unprecedented” events over the last decade in North Carolina Medicaid policy, and some people have joked that they pine to go back to “precedented” times. Objectively, the last decade has seen a collection of changes and events that have arguably aggregated to the most momentous changes to Medicaid in North Carolina since its passage 60 years ago.

First, the North Carolina General Assembly passed a statute in 2017 to launch Medicaid Transformation and applied for and received many waivers, including a pivot to Managed Care, the development of a substance use disorder waiver, and the launch of the Healthy Opportunities Pilots (HOP) program.

Amid the global COVID-19 pandemic, North Carolina launched Medicaid Transformation, moving 1.6 million people into prepaid health plans (PHPs). Medicaid enrollees received continuous coverage through the federal public health emergency (PHE) that was in place between 2020 and 2023. The end of the PHE in May 2023 led to an “unwinding” of the continuously-covered; however, Medicaid expansion in December 2023 provided coverage to nearly 700,000 North Carolinians, including over 200,000 on the first day.

This year, the HOP program ended on June 30, 2025, and the 119th Congress’ House Resolution 1 (HR1)¹ provided many substantial changes to Medicaid eligibility and financing over the coming years; it also included the Rural Health Transformation Program, which provides a generational opportunity to reform how rural health care is delivered.

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¹ This act is referred to by a number of names, including the One Big Beautiful Bill (OBBBA), HR1, and the Working Families Act. Throughout this issue, we tried to standardize to “HR1”.

All these changes occurred in the context of increased attention to health equity, especially among the evidence-based and documented differences in health outcomes, access, and utilization that populations living in North Carolina's rural counties or that minoritized racial and ethnic populations experience. This context is in stark contrast to the current reversal from that priority. These major changes mask an even larger number of more specific, but no less important to many, changes such as the advent of Tailored Plans, the Innovations Waiver, and the Child and Families Specialty Plan, which are specific programs for beneficiaries² with certain behavioral health conditions, those using home- and community-based services (HCBS), and current and former children in the foster care system. Although it is human nature to think that one is in especially atypical times, it is hard to argue that any decade has seen as much change to NC Medicaid as the last 10 years have witnessed.

As we review the last decade, and look ahead to what is coming, it is an opportune time to reflect on the current state of NC Medicaid:

- What is the current state of Medicaid in 2025?
- Who currently does and doesn't have access to care?
- How have policy changes like Medicaid expansion impacted coverage and care?
- Where have gaps been filled, and where do gaps still exist?

The purpose of our issue brief is to provide a global overview of where we are and where we are going—an acknowledgement of the changes that are coming. Of course, in 2000 words, we cannot possibly review all aspects of the topic, but we strive to provide some high-level assessments and refer the reader to the 11 commentaries, representing key stakeholders and perspectives across the state, for more details on the issues. The prevailing themes of these commentaries are, 1) an appreciation for the improvements and gains of the last few years; 2) a recognition that there is still work to do in our current state, in particular to ensure all communities are considered in NC Medicaid policy changes; and 3) trepidation over changes, some that are on the horizon and some that are already here.

Who Does Medicaid Cover?

It is helpful to begin with a current snapshot of who is enrolled in Medicaid. NC Medicaid has a series of highly informative dashboards, which allow the public and stakeholders to review current data across many areas of interest. Per the NC Medicaid Enrollment Dashboard, as of November 1,

² Those enrolled in Medicaid may be referred to as participants, clients, enrollees, or beneficiaries, among others; the North Carolina DHHS uses "beneficiaries" and so we largely follow that nomenclature,

2025, there were 3,098,104 North Carolinians enrolled in Medicaid; this represents over a quarter of all residents of the State.¹ Almost 690,000 were covered via expansion. Over 2 million were enrolled in a Standard Plan—Managed Care delivered via a PHP. Another 292,000 were enrolled in a Tailored Plan—Managed Care delivered through a plan focused on those with behavioral health conditions. From a demographic standpoint, a majority (55.7%) were female. Nearly half (45.4%) were 18 or younger, with another 9.1% aged 65 or over; 45.6% were within ages that might traditionally be referred to as “working age,” from 19 to 64. A majority (56%) were white, 37% Black or African-American, and other races (including multi-race) were all less than 3%. Just over 16% indicated they identified as Hispanic or Latino/a/e ethnicity.

Of course, “coverage” does not necessarily mean “access to health care.” At a high level, provider participation in Medicaid programs is not absolute; a study from 2016 found that 32% of providers saw 10 or fewer Medicaid patients in a year; thus, simple counts are not enough—measuring participation rates accurately requires a variety of measures to encompass all dimensions.^{2,3} The ability to get an appointment is clearly dependent on participation of local providers, as well as the capacity of the clinic to meet demand. Although there were concerns about the ability of providers to meet new demand associated with Medicaid expansion, physicians in expansion states have been found to increase their capacity to meet the new demand; primary care providers in expansion states increased their Medicaid appointments by 21%–29%.^{4,5} Meanwhile, other barriers to accessing health care, such as transportation and gaps in language access, are disproportionately experienced by Medicaid beneficiaries.^{6,7}

Access to health care will vary across populations. There is enormous evidence about persistent rural, racial, and ethnic health disparities in general—and in Medicaid specifically—with some evidence that expansion can narrow some disparities.^{8–12} Within North Carolina, one study found lower levels of trust among caregivers of Hispanic children (compared to non-Hispanic caregivers).¹³ Another study found higher levels of enrollment disruption among Hispanic children, and another study found that implementing pregnancy medical homes was effective at reducing poor outcomes among Black pregnancies.^{14,15}

These health disparities exist for reasons extending beyond the NC Medicaid program specifically; the evidence that Medicaid coverage and specific programs can be effective at narrowing disparities provides a compelling argument for the value of Medicaid. Although many commentaries throughout this issue cover this topic, two commentaries in particular explore it in depth. Martinez-Bianchi and Laws argue that although expansion has led to coverage gains and some improvement in outcomes through community-engaged partnerships, coverage is necessary, but not sufficient, to improve

the health of all North Carolinians. Plasencia and Tenenbaum propose the implementation of a Health Data Utility—essentially an expansion of the North Carolina Health Information Exchange—that can lead to health improvements for immigrants and populations that identify as Hispanic or Latino/a/e.

Additionally, urban majority-minority neighborhoods and rural areas tend to have lower access to health care, but Medicaid can help address that. An issue brief by the Medicaid and CHIP Payment and Access Commission (MACPAC) covers some salient facts.¹⁶ Adults and children covered by Medicaid are more likely to report access barriers than those covered by commercial plans and are less likely to report a usual source of care. Rural physicians were more likely to accept new Medicaid patients than urban physicians. Although there are parts of North Carolina that can be considered urban majority-minority neighborhoods, the conventional wisdom is that North Carolina is a rural state, and historically North Carolina has been a leader in developing innovative rural health models, including the first State Office of Rural Health in 1973.^{17,18} This is supported objectively by, for example, North Carolina having the 2nd largest rural population among the states. The commentary by Tillman and Johnson outlines rural-specific concerns, including a disinvestment in rural communities, with an eye toward the promise of the RHTP amid the impact of Medicaid cuts in HR1 on rural providers and residents. Senator Murdock's commentary discusses how Medicaid affects rural and urban communities differently, and how they may be differentially affected by changes going forward.

How is Medicaid Working for Specific Providers and Services?

Health care providers—professionals, facilities, organizations, and service providers—are key stakeholders in NC Medicaid. Their decisions of whether and how to participate, for example, are direct drivers of the access that beneficiaries have to their needed care. Hospitals were an integral part of the expansion policy discussion, with increased provider taxes being the major component of the state's share of the Medicaid cost; a state directed payment program known as Healthcare Access Stabilization Program (HASP) increased Medicaid reimbursement to commercial rates to help offset the new taxes.¹⁹ Unsurprisingly, evidence suggests that Medicaid expansion is financially positive for hospitals, so it is natural to expect that contraction would be financially concerning.²⁰⁻²² The North Carolina Healthcare Association's James Tucker outlines in his commentary concerns about upcoming changes resulting from HR1: a contraction in Medicaid coverage due to undoing the expansion, a decrease in state directed payments (i.e., HASP) supporting hospitals, and a decline in enrollment resulting from beneficiary community engagement requirements starting in 2027.

Safety-net organizations, such as Federally Qualified Health Centers (FQHCs), were expected to see considerable increases in insured populations—and thus revenue and financial strength—due to expansion.²³ ²⁴ In 2023, approximately one third of patients at North Carolina FQHCs were uninsured; a large number of them were expected to be eligible for Medicaid under expansion. Tammy Greenwell from Blue Ridge Health reports in her commentary that roughly 40% of the uninsured were indeed eligible for expansion, and FQHCs across the state saw a 2%–3% increase in patient revenue. This portends negative impacts to FQHCs and other safety net providers if expansion is eliminated.³

One of the more visible aspects of HR1 is the community engagement requirement (a.k.a., “work requirement”) for expansion adults.²⁵ Briefly, this provision requires adults covered via expansion to demonstrate “community engagement”—e.g., working, attending school, caregiving—at least every 6 months beginning no later than January 1, 2027. Certain populations (e.g., the medically frail, those who are pregnant, disabled veterans) are excluded. Notably, most adult Medicaid enrollees already work or are otherwise “community-engaged” in some capacity, and data from states that have tested this requirement suggest possible coverage losses and delayed medical care.²⁶⁻²⁸

The Congressional Budget Office has estimated that this provision is the largest driver of savings (or cuts, depending on your view) to the Medicaid program.²⁹ Thus, it has been one of the more visible foci of the implications of the legislation. However, other provisions, such as the provider taxes discussed above in the hospital context, will limit revenue that states have historically relied upon to fund optional services. One such program is Home- and Community-Based Services (HCBS), a service aimed at providing long term services and supports (LTSS) to individuals living with a disability and older adults living in their homes rather than in a facility.⁴

Thus, there are concerns nationally about the impact on eligible populations that would not be subject to the most visible aspects of HR1 (“community engagement”) and are in vulnerable positions, having conditions requiring long-term services and supports.^{30,31} In their commentary, Mary Bethel and colleagues outline the importance of Medicaid-supported HCBS services for the aging population—and challenges such as supporting the workforce.

³ Although not directly related to this specific Issue, the article by J. and P. Emmady in this issue outlines an innovative approach that safety net providers may consider – especially in the context of declining Medicaid support.

⁴ The *Olmstead* case requires the state to provide LTSS in the most integrated setting available, but the relationships between *Olmstead* and the Americans with Disability Act, HCBS as an optional Medicaid benefit, and LTSS as a required Medicaid benefit is complicated and beyond the scope of this brief. Interested readers may refer to “Twenty Years Later: Implications of *Olmstead v. L.C.* on Medicaid’s Role in Providing Long-Term Services and Supports” by the Medicaid Payment Advisory Commission.

Talley Wells's commentary discusses the role of Medicaid for those with intellectual and developmental disabilities. Both commentaries are acutely focused on workforce availability.

What's Working and What Should We Be Looking at Going Forward?

NC Medicaid has been implementing many innovative approaches, and evaluations of these have been relatively positive in demonstrating their benefits. The HOP program was an innovative model that addressed the long-recognized upstream socioeconomic drivers of health (e.g., interpersonal violence, homelessness, and hunger) that have historically been outside the purview of health care.³² Interim evaluations of this program have shown it to be effective at “bending the cost curve,” reducing costs from what they otherwise would have been.³³

A summative evaluation of the program is ongoing and due to the Centers for Medicare & Medicaid Services this spring. Evaluations of other aspects of the 1115 waiver (Managed Care transformations and substance use disorder) are also ongoing, with some early positive signs from interim evaluations. North Carolina Department of Health and Human Services Secretary Dev Sangvai's commentary outlines some of the successes from expansion and transformation and offers a sobering assessment of what is to come; Brianna Van Stekelenburg and colleagues comment on the potential application of lessons learned to help address upcoming fiscal challenges to Medicaid. Representative Donny Lambeth, a key figure in implementing North Carolina's expansion, discusses the successes of expansion and outlines some potential improvements.³⁴

Conclusion

Overall, there is a lot to celebrate about the current state of NC Medicaid, especially given the momentous developments of the past decade. While there will always remain challenges and program shortcomings that need to be addressed, there are a number of policies and programs that are working well and can be used more effectively. In this issue, the commentaries had generally positive reflections about where we are, while acknowledging key areas of concern and an uncertain, anxious future. We find NC Medicaid at an important crossroads, having achieved a number of strategic goals and weathered national and local storms (both figuratively and literally), and needing to shore up its position for what's to come. If history is any guide, the collaborative and innovative spirit of North Carolina's policymakers, health care providers, payers, residents, community leaders, and other stakeholders will help us put our best foot forward in where we are going.



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