SENATE PROPOSED MEDICAID POLICY: FISCAL IMPACT ON NORTH CAROLINA

NORTH CAROLINA ESTIMATES $32 BILLION IMPACT TO NORTH CAROLINA BUDGET AND HOSPITALS OVER THE NEXT DECADE.

The following information included in this document comes from data provided by the North Carolina General Assembly's Fiscal Research Division, the North Carolina Department of Health and Human Services, North Carolina Medicaid Program, and the North Carolina Healthcare Association. This includes estimated impacts to North Carolina and on hospitals on total Medicaid expenditures over a ten-year period resulting from select provisions in the Senate Finance Committee (SFC) proposal released on June 16, 2025. This analysis isolates the impact of the restrictions on provider taxes and SDPs, without incorporating any assumed enrollment reductions from the other provisions in the SFC.

METHODOLOGY AND ASSUMPTIONS

This analysis estimates the impact of proposed changes to Medicaid provisions included in the reconciliation proposal released by SFC on June 16, 2025.

The baseline estimates rely on public data sources, including the Transformed Medicaid Statistical Information System (T-MSIS), CMS-64 expenditure reports, approved state-directed payment (SDP) preprints, and survey data from hospital stakeholders on provider taxes.

The financial impact of changes to SDPs is modeled using publicly available preprint data, in combination with existing research on the ratio between commercial and Medicare payment rates across states, to project anticipated funding reductions.

For provider taxes, survey data from hospital stakeholders are used to determine taxes as a percentage of net patient revenue. Additional state-specific research was conducted to classify tax structures based on their likelihood of growing annually with inflation. For example, taxes calculated as a percentage of the most recent net patient revenue are assumed to grow annually under the SFC bill, whereas fixed-dollar taxes are assumed to remain static.

The model assumes that the temporary 5% Federal Medical Assistance Percentage (FMAP) bonus expires at the end of Federal Fiscal Year 2025. As a result, the expiration is incorporated into the baseline and not treated as a funding reduction in the modeling of policy impacts. The fiscal modeling provided by the North Carolina General Assembly's Fiscal Research Division did include the temporary 5% FMAP bonus and was treated as a funding reduction. This document also includes data and methodology from Manatt's Medicaid Financing Model.

NORTH CAROLINA IMPACTS

There are two potentially devastating impacts on North Carolina's Medicaid program due to this proposal.

1. The combination of increased administrative costs (Sections 71107 and 71124) and the provider tax phase down (Section 71120(a)) could result in the termination of Medicaid expansion in North Carolina because the costs would not be covered by existing assessment formulas. There are currently 663,000 expansion beneficiaries in NC.
2. The 3.5% provider tax cap (Section 71120(b)) would eliminate all or most of the Healthcare Access and Stabilization Program (HASP), a system of state directed payments to hospitals. Hospital assessments fund the State share of the HASP state directed payments. NC hospitals have received $4.9 billion of federal funds from the program this State fiscal year.

North Carolina law does not have a hospital provider tax rate; instead, it has two hospital assessment formulas, one for the non-expansion Medicaid population and one for the expansion population. These formulas calculate how much hospitals are assessed and how much public hospitals pay through intergovernmental transfers (IGTs). (Article 7B of Chapter 108A of the NC General Statutes)

Impact #1: Medicaid Expansion and Provider Taxes

By law, the North Carolina Department of Health and Human Services is required to end Medicaid expansion if the State cannot fully fund all the State and county costs associated with Medicaid expansion using (1) hospital assessment receipts (including IGTs), (2) the added insurance premiums taxes collected as a result of Medicaid expansion, and (3) any other State savings from expansion. (N.C.G.S. 108A-54.3B)

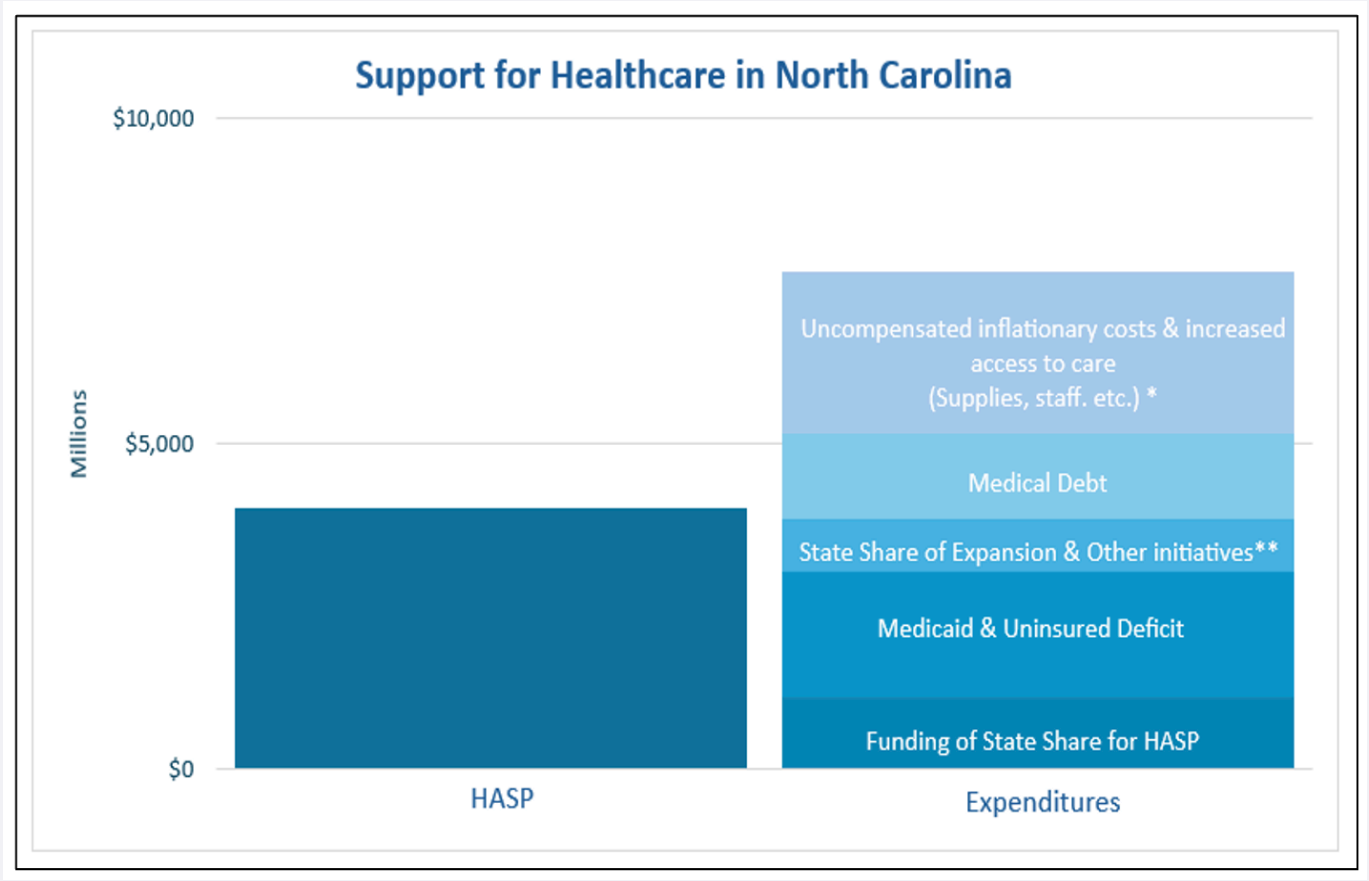
The community engagement requirements (Section 71124) and more frequent redeterminations (Section 71107) would increase administrative costs for expansion. Administrative costs are funded through a component in the expansion hospital assessment formula that is a fixed amount inflated over time (N.C.G.S. 108A-147.7). Because the provider tax freeze (Section 71120(a)) would not allow the fixed amount to be updated to reflect increased costs, new State funding for those costs could trigger the end of Medicaid expansion in NC.

Impact #2: HASP Directed Payments

North Carolina's hospital assessment formulas fund the following, in priority order (1) portion of the State share for the non-expansion Medicaid population, (2) nearly all the State share for the Medicaid expansion population, and (3) hospital directed payments through HASP. HASP was established as a part of NC's Medicaid expansion, designed to encourage hospital participation in managed care and maintain beneficiary access to care.

Reducing the provider tax cap to 3.5% would eliminate all or most of the HASP reimbursements for hospitals because there would not be a funding source for the State share without the assessment revenue (N.C.G.S. 108A-148.1). As outlined above, HASP will be eliminated first after experiencing funding reduction. This means that effectively everything else funded by provider taxes would be on the table for cuts or full elimination, depending on actions by the General Assembly. This includes home and community- based services, postpartum care for women 12 months post-birth, GME payments, rates for hospitals, and expansion.

SDP EXAMPLES IN NORTH CAROLINA



* There are various items for which hospitals use HASP funds. Examples from this section show that hospitals use these funds towards facility infrastructure needs to keep doors open, preserving maternity services in rural areas, investing in their current workforce and physician recruitment, and investing in services to meet the needs of individuals and of our aging population.

At least one rural hospital utilizes the funds to stabilize and recruit OB/GYN and maternity care in their area as their workforce is aging and retiring. Additionally, one rural hospital has begun providing oncology services in their area with their HASP funds to ensure cancer care can be provided closer to home. This is key to North Carolinians living in this rural county.

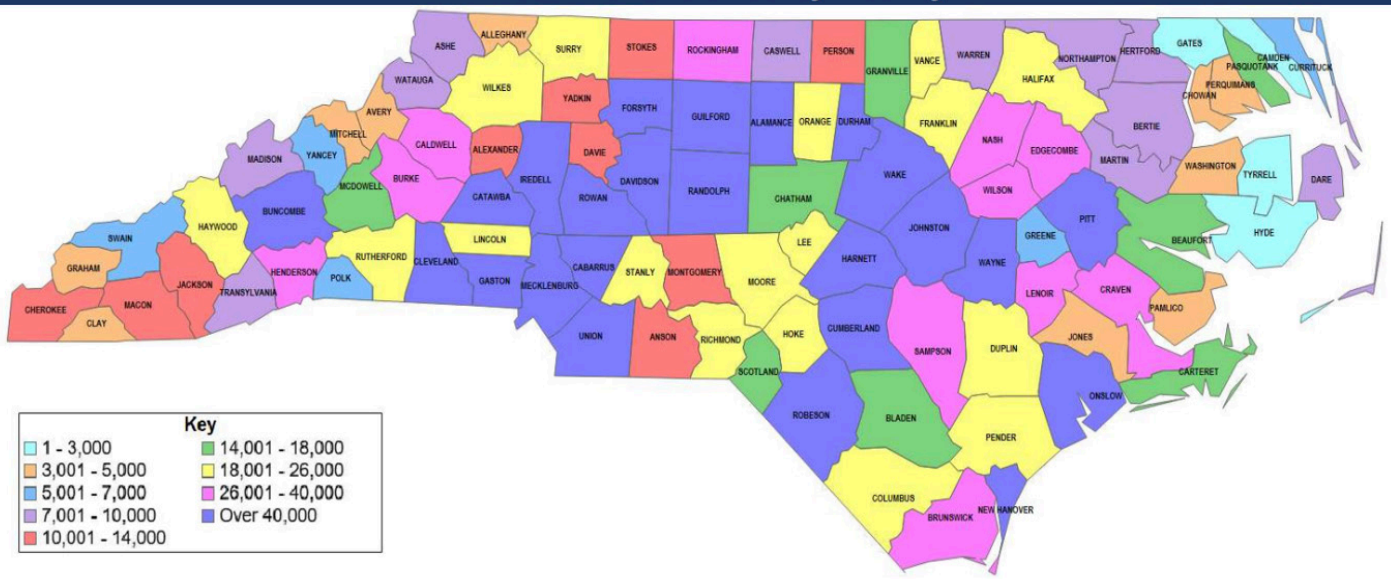
During June's extreme heat, a rural hospital off the coast of North Carolina had one-third of their HVAC units fail with no available parts in the area due to the age of the units. The hospital was able to fly in compressor parts to repair the HVAC units to keep their hospital open and comfortable for patients. HASP funds have helped this hospital stabilize and keep doors open.

Losing HASP funding would jeopardize critical service expansion projects – like a North Carolina health system's planned 150-bed behavioral health hospital – putting both future services and patient care at serious risk

** This includes Medicaid expansion for more than 650,000 North Carolinians, expanded home and community-based services, enhanced post-partum care coverage, graduate Medical Education, and state administrative costs for maintaining coverage.

MEDICAID IN NORTH CAROLINA

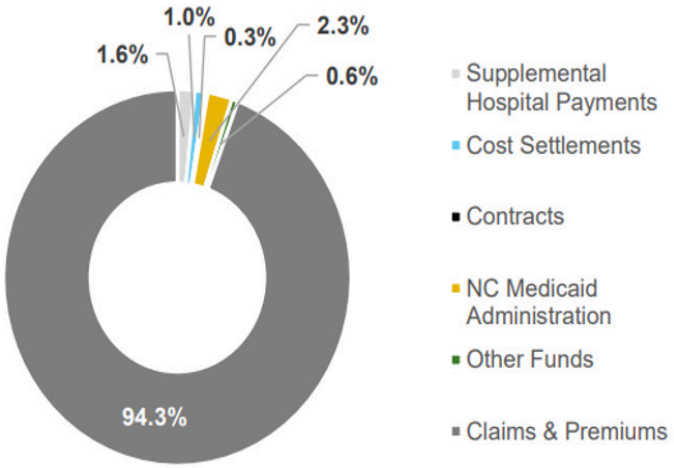
Total Beneficiaries by County



Most state fiscal year 2024 NC Medicaid expenditures (nearly $26.5 billion) paid for care to beneficiaries via claims and premiums (which includes HASP and Medicaid expansion) and other supplemental hospital payments. NC Medicaid Administration accounted for less than 2.5% of overall Medicaid expenditures.

Nearly **$26.2 billion** of NC Medicaid's total expenditures for state fiscal year 2024 went to claims and premiums.

Exhibit 2. $27.8 B Fund Level Expenditures | State Fiscal Year 2024




THOM TILLIS
U.S. SENATOR for NORTH CAROLINA