NC Minority Health Advisory Council Quarterly Meeting

Office of Minority Health & Health Disparities (OMHHD)

September 16, 2025

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Welcome and Member Roll Call

Luis Garcia Abundis

Data and Evaluation Program Manager

Meeting Agenda

1. **Welcome**
2. **Health Portfolio Updates**
   - Debra Farrington, Deputy Secretary
3. **Medicaid Updates**
   - LaQuana Palmer, Deputy Director Communications and Engagements
4. **Office of Minority Health Updates**
   - Portia Pope, Director
   - Carolina Siliceo-Perez, Acting Director Latinx/Hispanic Policy and Strategy
   - Tatiana Moore, Minority Diabetes Prevention Program Manager
5. **Questions / Closing Remarks**

Meeting Objectives

1. Enable MHAC members to better understand how NCDHHS and OMHHD function to eliminate health disparities and serve the people of NC.

2. Leverage the expertise of MHAC members to inform and support NCDHHS priorities related to addressing health disparities and provide a call to action for member involvement, feedback, and input.

Communication Considerations

Use the chat to ask questions. A meeting facilitator will read your question aloud to the group if there is time after each presentation section. Or, if there is not time, there is a dedicated discussion time reserved at the end.

Use the chat to provide insight or ideas during the presentation. All feedback and comments are welcome as the speakers present.

There is a dedicated **floor discussion** time later in this meeting.

If you come off mute to speak, please **state your name and affiliation** for the group before sharing.

NCDHHS and Health Portfolio Updates

Debra Farrington, MSW, LCSW

NCDHHS Deputy Secretary for Health

Communications & Engagement Updates

LaQuana Palmer, MPA
Division of Health Benefits (NC Medicaid)
Deputy Director, Communications and Engagement

NC Medicaid State Budget Reductions

LaQuana Palmer, MPA

Deputy Director, Communications and Engagement

Division of Health Benefits (NC Medicaid)

September 16, 2025

Briefing Agenda

- Overview of State Funding NC Medicaid
- Guiding Principles for Reductions
- Upcoming NC Medicaid Reductions
- Q&A

What Was Needed to Fully Fund NC Medicaid

Updated forecasts show that the need for the SFY 2025-26 Medicaid rebase is now **$819 million**, an increase from the $700 million request that was developed based on data from January.

NCDHHS and OSBM prepared for three different scenarios, with scenario 2 being enacted in SL 2025-89 (H125):

- Scenario 1: An appropriated rebase of $640 million, as proposed in the Senate's "mini budget" in late June, resulting in a budget gap of $179 million

- **Scenario 2: An appropriated rebase of $500 million, as originally proposed by both the House and Senate, resulting in a budget gap of $319 million**

- Scenario 3: No appropriated rebase in SFY 2025-26, resulting in a budget gap of $819 million

Current Funding for NC Medicaid

	Requested Funding	Funding in SL 2025-89 (H125)	Shortfall
Medicaid Rebase	$819 million	$600 million *$500 million for Rebase* *$82 million for Oversight* *$18 million for missing LME/MCO transfer*	$319 million *(=819-500)*
Medicaid Managed Care Oversight Fund	$115 million		$33 million *(=115-82)*
Technology for NC Medicaid	$13 million	$0	$13 million

Funding Challenges for NC Medicaid

There are several factors that make Medicaid budget reductions necessary this year absent a fully funded rebase:

- **No additional federal receipts**: Past budget gaps were covered by additional federal pandemic funds. These funds have ended.
- **Restricted funds from other sources**: Other funds are legally restricted per federal and state rules and can’t be used to support Medicaid.
- **No buffer in the Medicaid budget**: Medicaid ended FY 2024–25 on budget, spending $34 billion and reverting only $9,000. Any carryforward funds will be used for costs incurred but not paid in the prior fiscal year.

Medicaid Rebase Shortfall

SFY	Difference between Requested funding and Enacted Budgets	Primary offsets & Mitigating Factors
2019-20	**$(48,441,296)**	Depressed Fee For Service spend + Federal COVID Families First Coronavirus Response Act (FFCRA) Funding
2020-21	**$(234,117,130)**	Federal COVID FFCRA funding
2021-22	**$(35,000,000)**	Federal COVID FFCRA funding
2022-23	**$(184,231,095)**	Federal COVID FFCRA funding
2023-24	**$(212,727,253)**	Tailored Plan delay + $95m in Federal Home and Community Based Services (HCBS) additional receipts
2024-25	**$(81,001,256)**	Federal e14 waiver effect + delayed launch of Children & Families Specialty Plan (CFSP)
2025-26	**$(319,000,000)**	None projected

Considerations for Making Reductions

- **Minimize impact to services for vulnerable populations** like children and people with disabilities
- **Minimize impact to critical behavioral health services** so the state can continue making progress in addressing the current behavioral health crisis
- **Minimize impact to providers** who have not had rate increases for over a decade
- **Minimize impact to home and community-based services** since the alternative is higher cost care in institutional settings
- **Make reductions that are more easily reversible** (for example: rate cuts versus eliminating whole services) in case additional funding becomes available or utilization trends show a more favorable long-term forecast

NC Medicaid Reductions Effective October 1

In a managed care environment, there are two main ways to address a shortfall from an insufficient rebase:

1. Reduce provider reimbursement rates

2. Reduce optional services

NCDHHS is required by federal regulations to provide actuarially-sound capitation rates for managed care organizations.

Actuarially sound rates reflect expected costs based on prior utilization, health care inflation, projected trends, administrative expenses, and state taxes like NC's 1.9% premium tax.

NC Medicaid Reductions Effective October 1

Provider Rate Reductions → $240,099,039

3% reduction for all providers and **8% or 10%** reductions for select services

10% Service Reductions

Inpatient – Physical Health (note: 55% of non-federal share funded by provider tax)
Outpatient Hospital – Physical Health Facility (note: 55% of nf share funded by provider tax)
Outpatient Hospital – Physical Health Professional
Emergency Room – Physical Health (note: 55% of nf share funded by provider tax)
Emergency Room – Behavioral Health
Physician – Specialty
Nursing Home (note: 13% of per diems funded by provider tax)
Research-based Behavioral Health Treatment/Applied Behavioral Analysis (RB-BHT/ABA)
Psychiatric Residential Treatment Facility (PRTF)

NC Medicaid Reductions Effective October 1

Provider Rate Reductions → $240,099,039

3% reduction for all providers and **8% or 10%** reductions for select services

8% Service Reductions

Physician - Primary Care
Family Planning Services (note: 90% FMAP)
Other Professional – Physical Health
Personal Care Services (PCS)
Hospice
Inpatient – Behavioral Health
Outpatient – Behavioral Health
Community Support
Behavioral Health Long-term Residential
Intermediate Care Facility/Individuals with Developmental Disability (note: approx. 10% of per diems funded by provider tax)
Long-Term Residential Day Supports (LTRDS)
Other Services – Behavioral Health

NC Medicaid Reductions Effective October 1

Provider Rate Reductions → **$240,099,039**

3% reduction for all providers and **8% or 10%** reductions for select services

Reductions in provider reimbursement rates will:

- Increase financial pressure on health care providers
- Potentially lead providers to stop serving Medicaid beneficiaries due to unsustainable payment rates
- Decrease access to care for Medicaid recipients — with rural communities likely to be disproportionately affected

NC Medicaid Reductions Effective October 1

Pre-paid Health Plans Rate Reductions → $44,000,000

- 1.5% capitation rate reduction for Standard Plans
- A capitation rate is a fixed amount of money paid per patient per month to a health care provider in advance, regardless of how many services the patient uses. 1.5% is the maximum flexibility allowed by CMS

Service eliminations → $36,500,000

- GLP-1 drugs for weight loss – Added in 2024 to improve health outcomes and reduce future costs. Still required to cover GLP-1s for other clinical needs like diabetes and heart disease. Will continue to cover other rebate eligible drugs for the indication of weight loss
- Integrated Care for Kids Pilot – NC InCK (Standard Plan & Tailored Plans) – Coordinated approach that combines physical health, mental health, and social services to address the whole child's needs in a collaborative way. This will end Medicaid's financial commitments to InCK early.

Compounding Pressures Threaten Program Stability

- **State underfunding of administrative costs (SL 2025-89)** will result in reductions in temporary staff and contractors who support core operations, termination of critical contracts, halting of projects, and reduced compliance and quality oversight.

- **Healthy Opportunities Pilots (HOP)** remain unfunded. With the loss of both HOP and GLP-1 drugs for weight loss, NC Medicaid loses two critical tools to reduce long-term health care costs.

- **Federal mandates (H.R.1)** impose new Medicaid work requirements and more frequent eligibility checks – without sufficient funding to implement them.

- **Re-procurement of Standard & Tailored Plans** delayed 2 years due to administrative funding shortfalls and ongoing program uncertainty limiting ability to improve the member and provider experience in ways that lead to better clinical outcomes.

Multiple Pressures Threaten to Erode NC's Strong Medicaid Program

- Cuts to provider taxes and State Directed Payments
- Eliminating programs proven to reduce costs
- Inadequate funding for operations and administration
- Implementing new federal requirements
- Medicaid expansion is at risk
- Not fully funding the Medicaid Rebase

NC MEDICAID

Next Steps

- **Now** – Begin preparing required paperwork for every provider rate change to CMS and begin amending/updating contracts
- **August 13** – Briefing with provider stakeholders
- **August 26-28** – NC General Assembly Session
- **Early September** – Bulletin sent to providers of Oct. 1 rate changes
- **Early September** – Notice sent to beneficiaries regarding service reductions
- **September 8-30** – Update claims and billings systems
- **September 22-25** – NC General Assembly Session
- **October 1 –** Lower provider rates and service reductions go into effect

NC Medicaid Provides Affordable Health Coverage to 3.1 Million People

NC Medicaid Snapshot

August 2025 total enrollment: **3,121,580**

which includes

August 2025 Medicaid expansion enrollment: 678,335

Gender		
FEMALE	55.8%	1,740,007
MALE	44.2%	1,375,558
Grand Total	100.0%	3,115,565

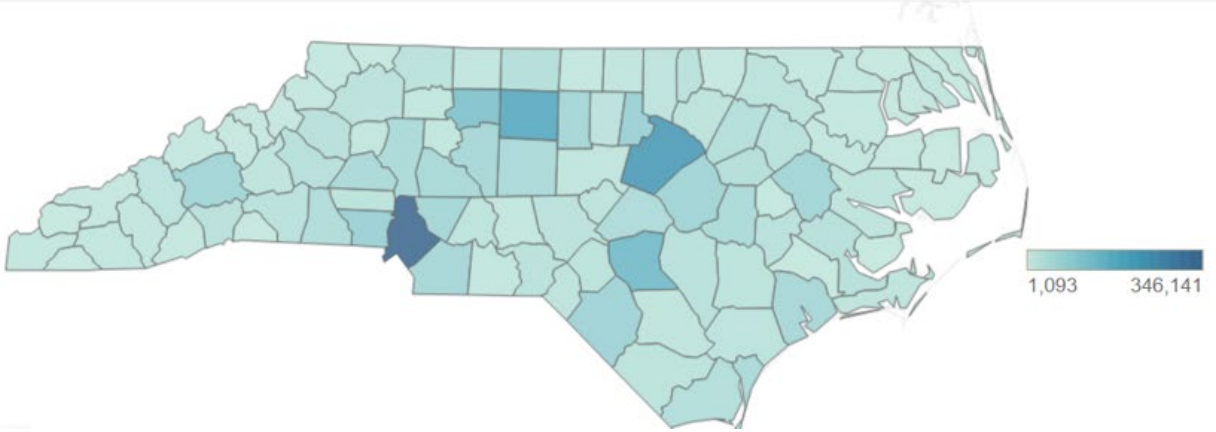
Race		
WHITE/CAUCASIAN	56.2%	1,750,472
BLACK/AFRICAN AMERICAN	37.0%	1,152,518
ASIAN	2.2%	67,013
MULTI RACE*	1.9%	58,570
AMERICAN INDIAN OR ALASKAN	1.6%	48,467
UNREPORTED	1.1%	33,552
NATIVE HAWAIIAN OR OTHER PACIFIC ..	0.2%	4,973
Grand Total	100.0%	3,115,565

** If a person selects more than 1 racial group, they are considered multi racial.*

Age Group		
0-5	14.2%	441,793
6-18	31.5%	981,622
19-20	3.7%	113,988
21-44	27.2%	845,997
45-64	14.6%	455,179
65+	8.9%	276,986
Grand Total	100.0%	3,115,565

Ethnicity		
NOT HISPANIC OR LATINO	81.4%	2,537,205
OTHER HISPANIC OR LATINO	10.5%	326,426
HISPANIC MEXICAN AMERICAN	4.2%	131,696
UNREPORTED	2.5%	77,235
HISPANIC PUERTO RICAN	1.0%	32,592
HISPANIC CUBAN	0.3%	10,197
Grand Total	100.0%	3,115,351

Enrollment by County



Questions

Follow up questions:
Medicaid.NCEngagement@dhhs.nc.gov

Office of Minority Health Updates

Portia D. Pope, Ph.D., MPA, PMP, LSSGB, NCCM, IMH-E

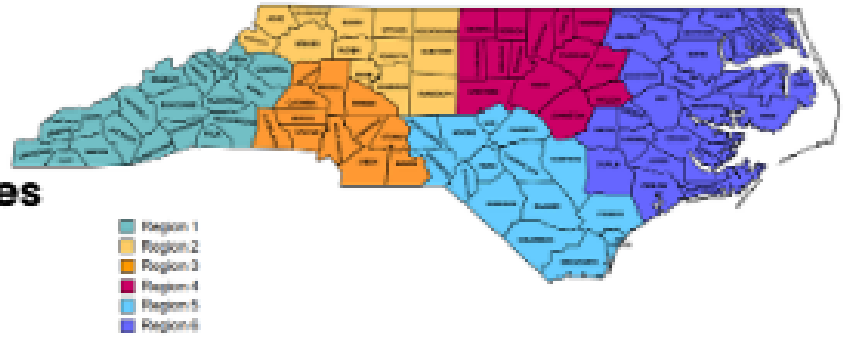
Director, Office of Minority Health and Health Disparities

Strengthening Pathways to Access to Care

Overview

Sessions aim to provide health navigation information to equip community health workers, faith institutions, and community organizations with the tools and information needed to help individuals navigate the different pathways that currently exist to access health coverage and services. The goal of the sessions is to increase information regarding access to primary care, preventive screenings and health care management services.

Region 4: April 24th, 2025 Special Focus: **Cancer Navigation**
Chapel Hill
Region 6: June 17th, 2025 Special Focus: **Oral Health**
Greenville
Region 1: July 17th, 2025 Special Focus: **Mental Health/Disability Services**
Asheville
Region 2: August 5th, 2025 Special Focus: **Cancer Navigation**
Winston Salem
Region 5: August 19th, 2025 Special Focus: **Diabetes**
Wilmington
Region 3: September 25th, 2025 Special Focus: **Disability Services**
Charlotte



"The Latinx and Hispanic community is 2.08 times more likely to not see a doctor due to cost."

Strengthening Pathways Access to Care Region 3

Partners for Region 3 Access to Care Training:

- Partners are:
  - Care Share Health Alliance
  - North Carolina Community Health Center Association
  - Mecklenburg County Health Department
  - NC Navigator Consortium
  - LILA LGBTQI+ Initiative
  - Grupo Poder y Esperanza
  - Blue Cross Blue Shield of North Carolina

Access to Care Working Group Community and Partner Engagement

250,000 INDIVIDUALS/ORGANIZATIONAL REACH

ACCESS TO CARE SESSIONS

Our sessions engaged with **265 organizational partners**, **180** of which attended sessions in person.

- 265 ORGANIZATIONS REGISTERED
- 180 ATTENDED IN PERSON
- 20 PARTNERS PRESENTING

6 REGIONAL SESSIONS

SUPPORT FOR SPECIAL TOPICS

- ATRIUM HEALTH
- ECU SONRIE CLINIC
- GRUPO PODER Y ESPERANZA
- VAYA HEALTH
- PROJECT ACCESS WCMS
- LILA LATINX LGBTQI+ IINITATIVE
- SISTAS 4 SISTAS
- CUBRE TU CABEZA NO TU CORAZON
- NC JUSTICE CENTER
- COMMUNITY HEALTH NETWORK OF NC

PARTNER Organizations

NCCHCA — North Carolina Community Health Center Association

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Minority Health and Health Disparities

CARE SHARE Health Alliance

North Carolina

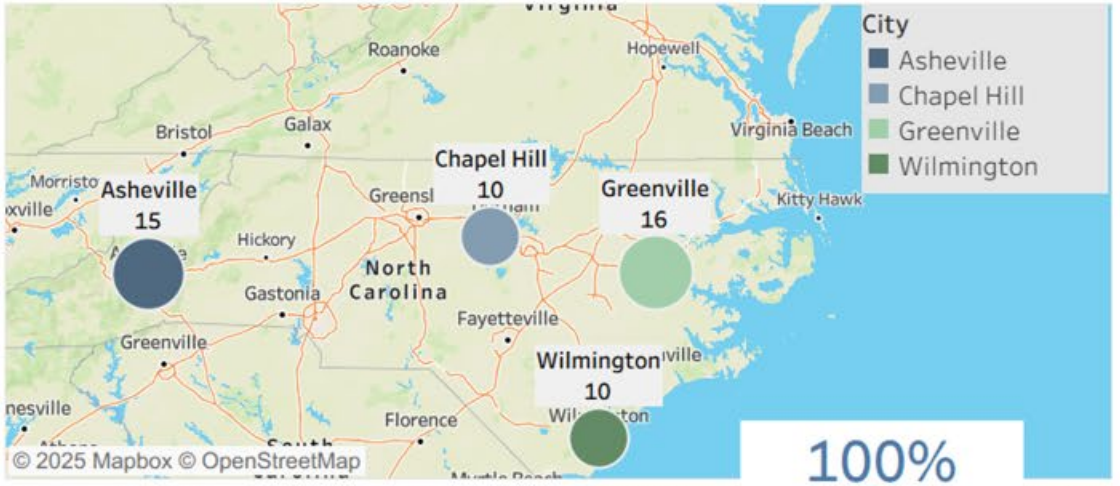
NC NAVIGATOR CONSORTIUM

Access to Care Sessions – Feedback Over (2025)

Access to Care Sessions - Feedback Overview (2025)

51	84%	4.51
# of Responses	Recommendation Rate	Language Interpretation Quality Score
98%		
New Partnerships		

City: (All)



100%
Information Helpful

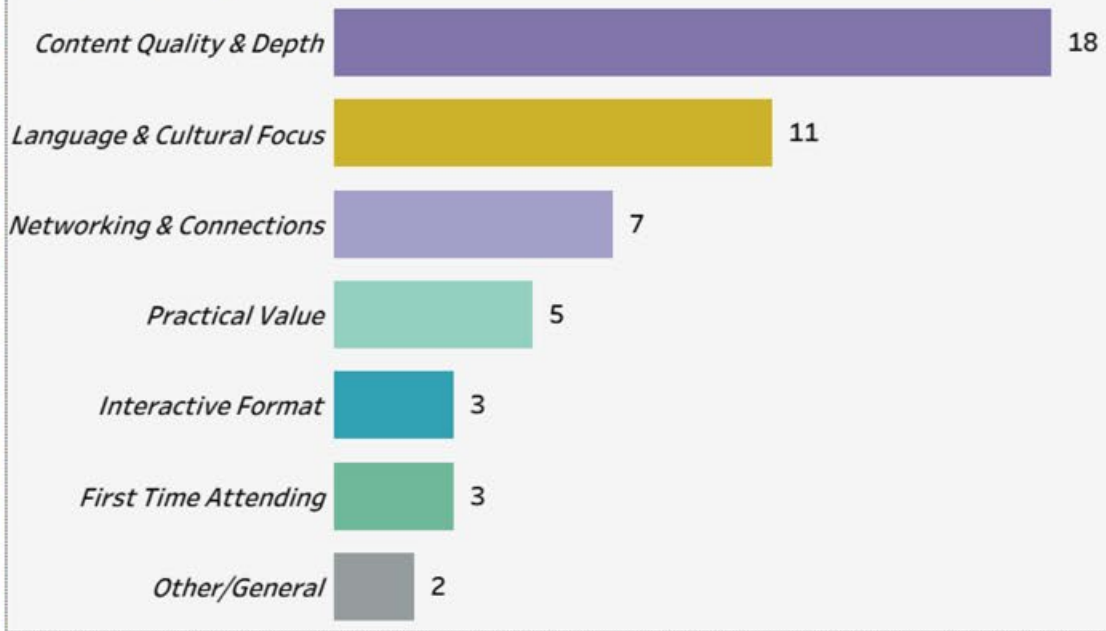
Support Preferences

Digital Delivery	Email	13
	Social Media/Online	2
In-person Events	Community Events	5
	Workshops/Training	4
	Physical Materials	1
Ongoing Partnership	Future Collaboration	3
	Comprehensive Support	3
Resource Sharing	Information Sharing	6
	Physical Materials	2
Direct Connections	Contact Lists/Directories	7
Networking & Collaboration	Networking Opportunities	3

Comments Highlights

Gratitude/Positive Feedback	16
Request for more sessions	12
Suggestions/Improvement	5
Translation Issues	3
Need for alternative times	3
Request for follow-up material materials	2

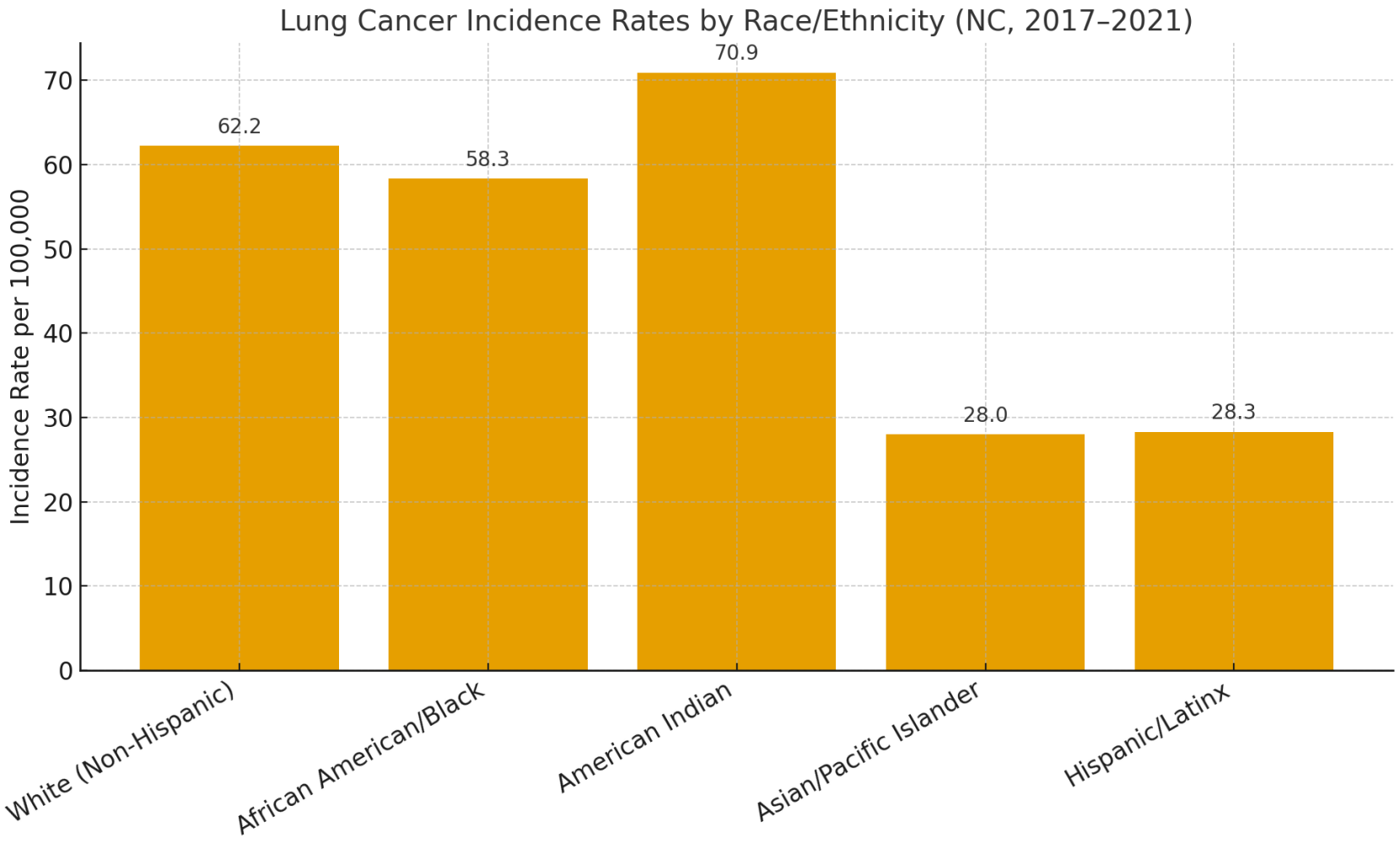
Key Highlights of Session



NC Lung Cancer

- Chronic (long-term) disease often develop due to mix of health behaviors, genetics, and environment. These diseases are major causes of death in North Carolina
- Radon is the second leading cause of lung cancer in the United States (after smoking).
- Long-term exposure to elevated radon levels increase the risk of lung cancer, even in non-smokers

Data Analysis of NC Lung Cancer



As shown in Graph 1:

- Lung Cancer incidence in North Carolina highest among American Indians (70.9 per 100,000), followed by whites (62.2%) and African Americans (58.3%)
- Rates are substantially lower among Hispanic/Latinx (28.3%) and Asian/Pacific Islander populations (28.0%)

Highlighting both elevated risks in some communities of color and opportunities for targeted screening and outreach

Graph 1

Lung Cancer in NC: Disparities by Race/Ethnicity

Highest rates:

- American Indian Communities (70.9 per 100,000)

Comparable rates:

- White (62.2%) and African American (58.3%)

Lower rates:

- Hispanic/Latinx (28.3%) and Asian/Pacific Islander (28.0%)

Disparity concern:

- Elevated burden among American Indians signals the need for targeted prevention and screening

Opportunity:

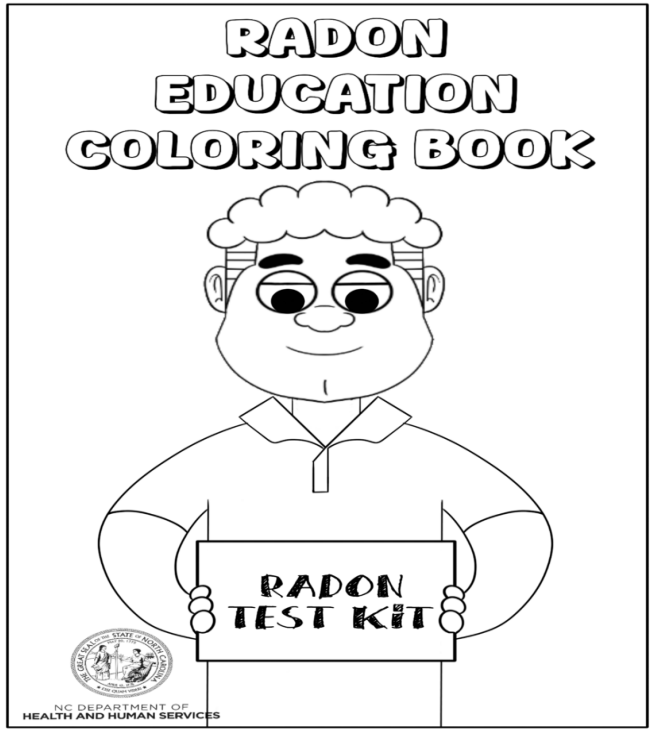
- Lower rates in Hispanic/Latinx and Asian/Pacific Islander groups should not mask barriers in access, early detection, and culturally responsive education

Radon Health Project

NCDHHS OMHHD Staff and Experiential Learning and Opportunity Internship Program Interns, in collaboration with the NCDHHS Radon Program Radiation Protection Section (RPS) of the Division of Health Service Regulation developed a **Radon Education Toolkit and Radon Education Coloring Book** in an effort to increase public awareness and understanding of radon gas, its health risks, and the importance of testing and mitigation to protect human health.

Radon Education Toolkit

- Radon is the second leading cause of lung cancer in the United States
- A comprehensive guide to radon risks and prevention
- Designed to inform and empower North Carolina resident, institutions, and professionals with information about radon
- Provides many resources from informational videos to infographics to make learning about radon easy for everyone



**Coming Soon

HMP Connections Meeting

- Next Session is scheduled for **October 7, 2025 -** 12 PM to 1 PM
- Guest Organization: **North Carolina Down Syndrome Alliance**

  Title: "**Celebrating Abilities: Advancing Inclusion for People with Down Syndrome"**
- Featured Speaker:

  Christy Cooper, Co-Director

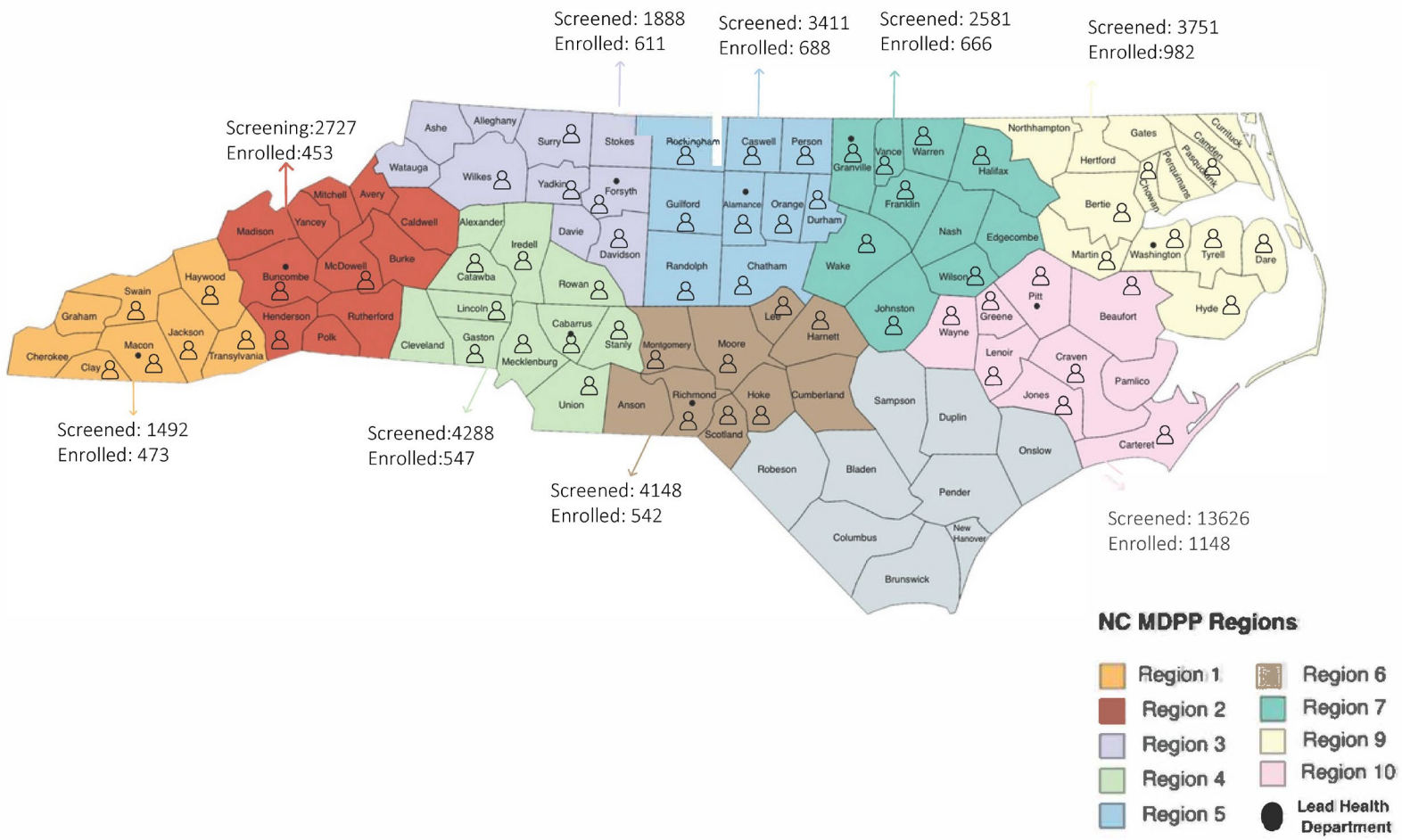
  North Carolina Down Syndrome Alliance

Minority Diabetes Prevention Program (MDPP) Updates

Tatiana Moore, MPH, RDN, LDN, IBCLC

NC Minority Diabetes Prevention Program (MDPP) Program Manager

County Representation and Impact Since 2017



NC MDPP FY 25 Goals

Key Performance Indicator (KPI)	Goal	Status as of 06/30/25	Achievement
Prediabetes Screening	1365 people screened	3512 people screened	257%
MDPP Enrollment	410 people enrolled	566 people enrolled	138%
12-month Lifestyle Class Series	32 classes conducted	49 classes conducted	153%
Living Well Events	8 events held	8 events held	100%

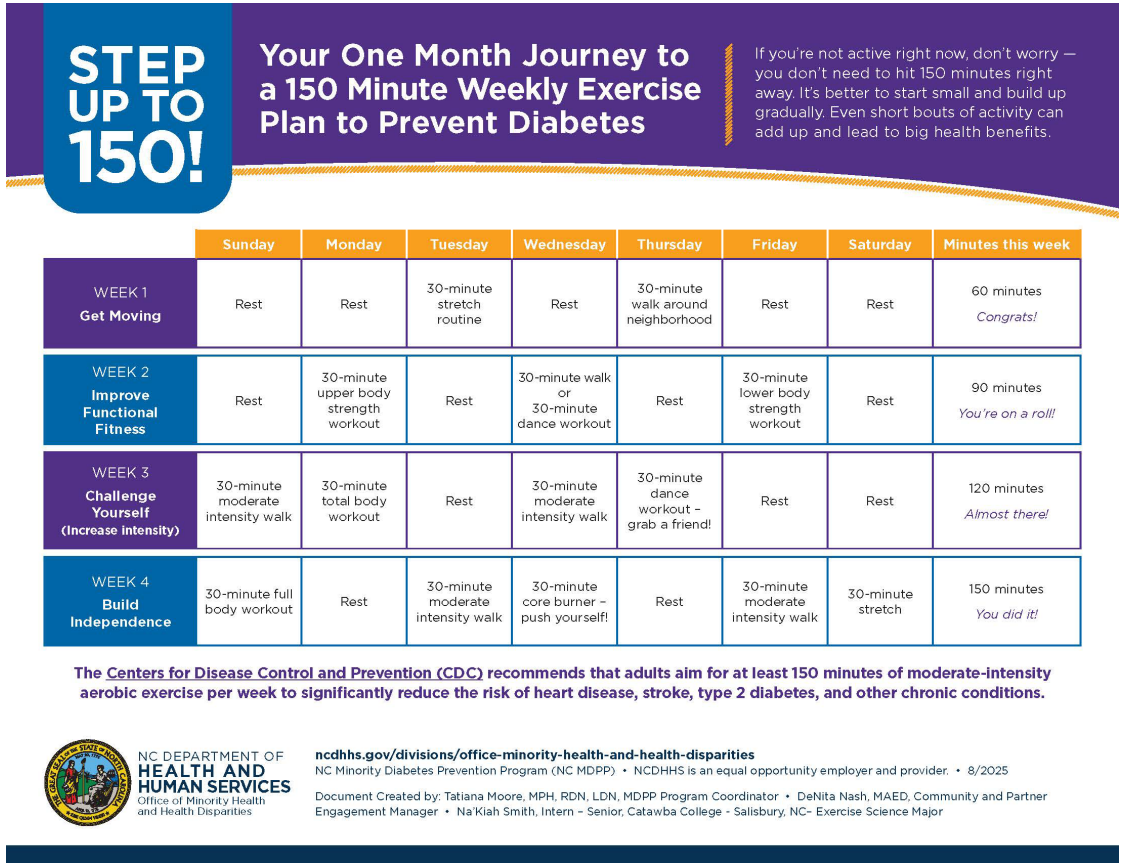
New NC MDPP Partnerships

- Cone Health - Diabetes Council
- UNCG - Dr. Debra Neblett

New NC MDDP Supplemental Resources

- **New NC MDPP Program Health Initiative Campaign**
  - Available in English and Spanish
  - Provides culturally tailored, accessible resources to prevent type 2 diabetes in historically marginalized communities
- ***NC MDPP Program Overview***
  - Raises awareness that **1 in 3 adults has prediabetes**
  - Highlights impact (38,000 screened, 5,700 enrolled)
  - Explains the program clearly with who it serves, how it works, and the free support offered in both English and Spanish.

New NC MDDP Supplemental Resources



STEP UP TO 150!

Your One Month Journey to a 150 Minute Weekly Exercise Plan to Prevent Diabetes

If you're not active right now, don't worry — you don't need to hit 150 minutes right away. It's better to start small and build up gradually. Even short bouts of activity can add up and lead to big health benefits.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Minutes this week
WEEK 1 **Get Moving**	Rest	Rest	30-minute stretch routine	Rest	30-minute walk around neighborhood	Rest	Rest	60 minutes *Congrats!*
WEEK 2 **Improve Functional Fitness**	Rest	30-minute upper body strength workout	Rest	30-minute walk or 30-minute dance workout	Rest	30-minute lower body strength workout	Rest	90 minutes *You're on a roll!*
WEEK 3 **Challenge Yourself (Increase intensity)**	30-minute moderate intensity walk	30-minute total body workout	Rest	30-minute moderate intensity walk	30-minute dance workout – grab a friend!	Rest	Rest	120 minutes *Almost there!*
WEEK 4 **Build Independence**	30-minute full body workout	Rest	30-minute moderate intensity walk	30-minute core burner – push yourself!	Rest	30-minute moderate intensity walk	30-minute stretch	150 minutes *You did it!*

The Centers for Disease Control and Prevention (CDC) recommends that adults aim for at least 150 minutes of moderate-intensity aerobic exercise per week to significantly reduce the risk of heart disease, stroke, type 2 diabetes, and other chronic conditions.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Minority Health and Health Disparities

ncdhhs.gov/divisions/office-minority-health-and-health-disparities
NC Minority Diabetes Prevention Program (NC MDPP) • NCDHHS is an equal opportunity employer and provider. • 8/2025

Document Created by: Tatiana Moore, MPH, RDN, LDN, MDPP Program Coordinator • DeNita Nash, MAED, Community and Partner Engagement Manager • Na'Kiah Smith, Intern – Senior, Catawba College - Salisbury, NC– Exercise Science Major

- ***"Step Up to 150"***
  - Encourage adults to reach the CDC's recommendation of 150 minutes of moderate-intensity exercise per week
  - Aims to lower risk of not only type 2 diabetes but of heart disease, stroke, and other chronic conditions.
  - A 4-week progressive plan that gradually builds physical activity habits.
  - Also available for Spanish speaking audiences

New NC MDDP Supplemental Resources

- ***Power Plate: Eat Smart***
  - Teaches communities how to build balanced meals
  - Practical, easy-to- follow food planning strategies.
  - Educates about having a balanced plate fuels the body, which steadies blood sugar, and supports long-term health.

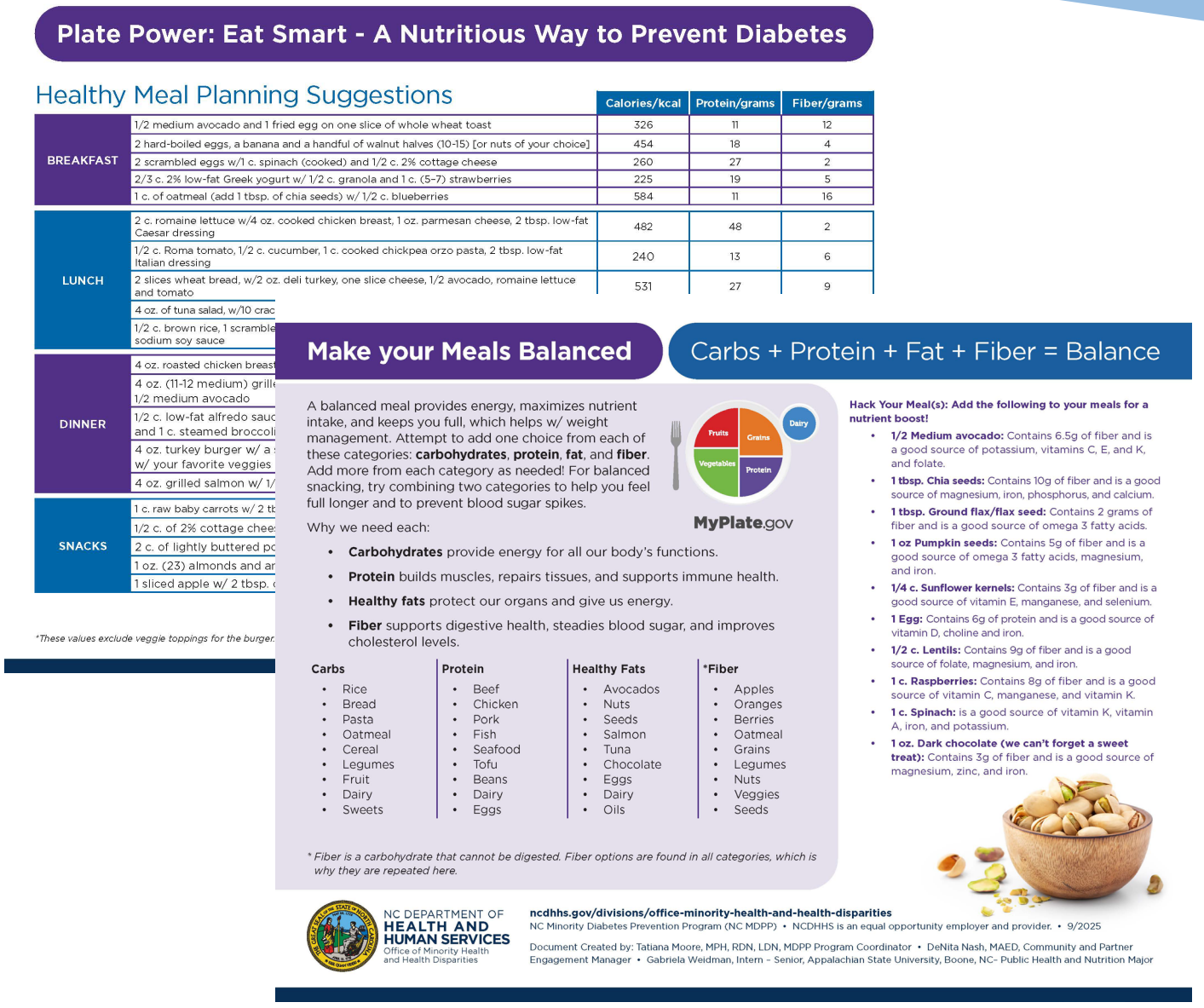


Plate Power: Eat Smart - A Nutritious Way to Prevent Diabetes

Healthy Meal Planning Suggestions

		Calories/kcal	Protein/grams	Fiber/grams
BREAKFAST	1/2 medium avocado and 1 fried egg on one slice of whole wheat toast	326	11	12
	2 hard-boiled eggs, a banana and a handful of walnut halves (10-15) [or nuts of your choice]	454	18	4
	2 scrambled eggs w/1 c. spinach (cooked) and 1/2 c. 2% cottage cheese	260	27	2
	2/3 c. 2% low-fat Greek yogurt w/ 1/2 c. granola and 1 c. (5-7) strawberries	225	19	5
	1 c. of oatmeal (add 1 tbsp. of chia seeds) w/ 1/2 c. blueberries	584	11	16
LUNCH	2 c. romaine lettuce w/4 oz. cooked chicken breast, 1 oz. parmesan cheese, 2 tbsp. low-fat Caesar dressing	482	48	2
	1/2 c. Roma tomato, 1/2 c. cucumber, 1 c. cooked chickpea orzo pasta, 2 tbsp. low-fat Italian dressing	240	13	6
	2 slices wheat bread, w/2 oz. deli turkey, one slice cheese, 1/2 avocado, romaine lettuce and tomato	531	27	9
	4 oz. of tuna salad, w/10 crac			
	1/2 c. brown rice, 1 scramble sodium soy sauce			
DINNER	4 oz. roasted chicken breas			
	4 oz. (11-12 medium) grille 1/2 medium avocado			
	1/2 c. low-fat alfredo sauc and 1 c. steamed broccoli			
	4 oz. turkey burger w/ a w/ your favorite veggies			
	4 oz. grilled salmon w/ 1/			
SNACKS	1 c. raw baby carrots w/ 2 tb			
	1/2 c. of 2% cottage chee			
	2 c. of lightly buttered pc			
	1 oz. (23) almonds and ar			
	1 sliced apple w/ 2 tbsp.			

*These values exclude veggie toppings for the burger.

Make your Meals Balanced

Carbs + Protein + Fat + Fiber = Balance

A balanced meal provides energy, maximizes nutrient intake, and keeps you full, which helps w/ weight management. Attempt to add one choice from each of these categories: **carbohydrates**, **protein**, **fat**, and **fiber**. Add more from each category as needed! For balanced snacking, try combining two categories to help you feel full longer and to prevent blood sugar spikes.

MyPlate.gov

Why we need each:

- **Carbohydrates** provide energy for all our body's functions.
- **Protein** builds muscles, repairs tissues, and supports immune health.
- **Healthy fats** protect our organs and give us energy.
- **Fiber** supports digestive health, steadies blood sugar, and improves cholesterol levels.

Carbs	Protein	Healthy Fats	*Fiber
Rice	Beef	Avocados	Apples
Bread	Chicken	Nuts	Oranges
Pasta	Pork	Seeds	Berries
Oatmeal	Fish	Salmon	Oatmeal
Cereal	Seafood	Tuna	Grains
Legumes	Tofu	Chocolate	Legumes
Fruit	Beans	Eggs	Nuts
Dairy	Dairy	Dairy	Veggies
Sweets	Eggs	Oils	Seeds

Fiber is a carbohydrate that cannot be digested. Fiber options are found in all categories, which is why they are repeated here.

Hack Your Meal(s): Add the following to your meals for a nutrient boost!

- **1/2 Medium avocado:** Contains 6.5g of fiber and is a good source of potassium, vitamins C, E, and K, and folate.
- **1 tbsp. Chia seeds:** Contains 10g of fiber and is a good source of magnesium, iron, phosphorus, and calcium.
- **1 tbsp. Ground flax/flax seed:** Contains 2 grams of fiber and is a good source of omega 3 fatty acids.
- **1 oz Pumpkin seeds:** Contains 5g of fiber and is a good source of omega 3 fatty acids, magnesium, and iron.
- **1/4 c. Sunflower kernels:** Contains 3g of fiber and is a good source of vitamin E, manganese, and selenium.
- **1 Egg:** Contains 6g of protein and is a good source of vitamin D, choline and iron.
- **1/2 c. Lentils:** Contains 9g of fiber and is a good source of folate, magnesium, and iron.
- **1 c. Raspberries:** Contains 8g of fiber and is a good source of vitamin C, manganese, and vitamin K.
- **1 c. Spinach:** is a good source of vitamin K, vitamin A, iron, and potassium.
- **1 oz. Dark chocolate (we can't forget a sweet treat):** Contains 3g of fiber and is a good source of magnesium, zinc, and iron.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Minority Health and Health Disparities

ncdhhs.gov/divisions/office-minority-health-and-health-disparities

NC Minority Diabetes Prevention Program (NC MDPP) • NCDHHS is an equal opportunity employer and provider. • 9/2025

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Any Questions, Comments, or Feedback?

Open Discussion

Closing Remarks

Contact Us:

- Office of Minority Health:
  - OMHHD@dhhs.nc.gov
- Dr. Portia Pope, Deputy Director, OMHHD:
  - Portia.D.Pope@dhhs.nc.gov

Resources:

- Office of Minority Health and Health Disparities Website
- Health Portfolio Website
- Community & Partner Engagement (CPE) Website
  - CPE Resources Page
- MHAC Website

NC Minority Health Advisory Council Post-Session Survey (September 2025)

Link to survey

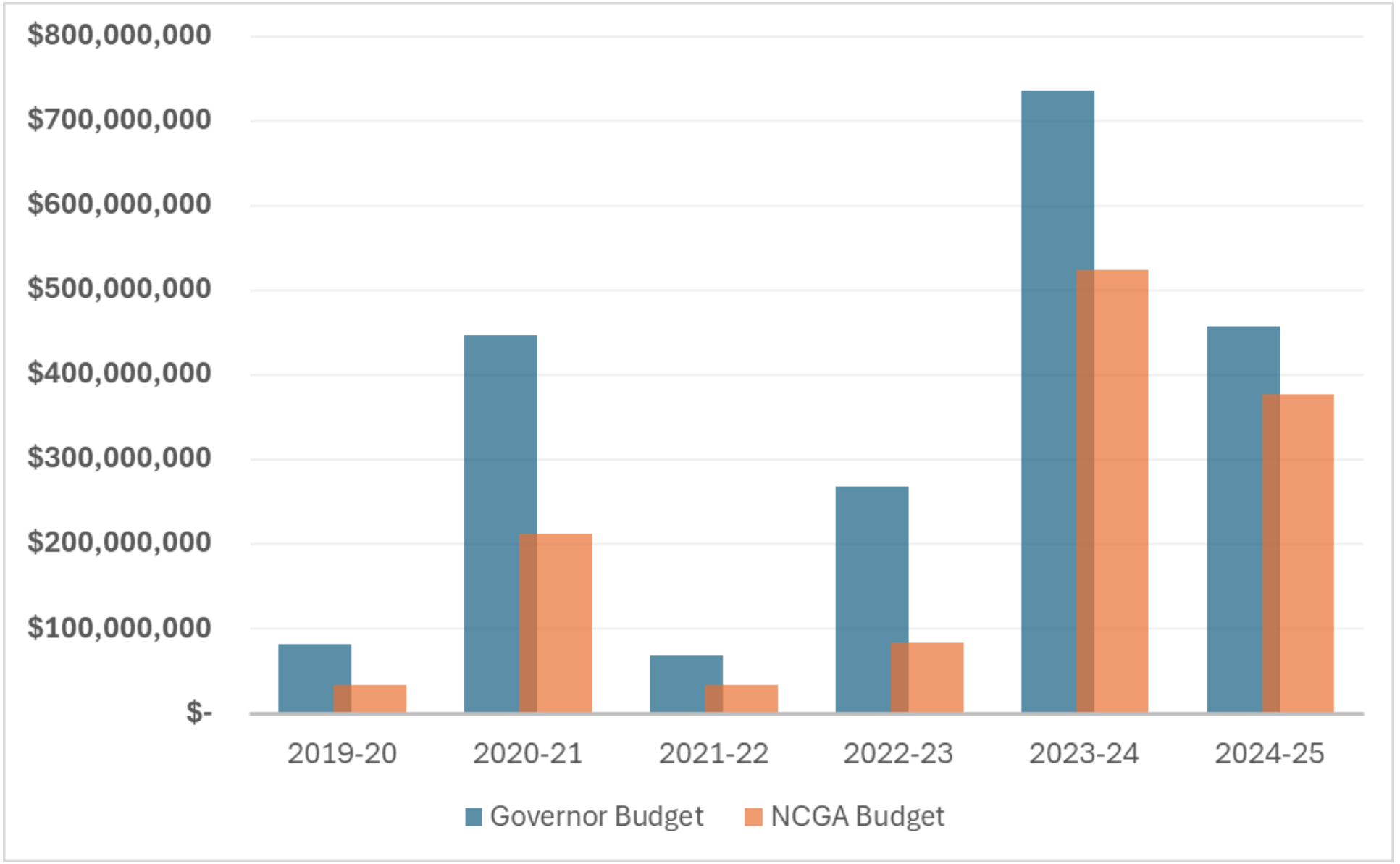
Thank you!

NC Minority Health Advisory Council Quarterly Meeting

September 16, 2025

Appendix

Funding History for NC Medicaid



Fee-for-Service vs Managed Care

- Fee-for-Service and Managed Care are two primary delivery and payment models.
  - Under fee-for-service, the state pays health care providers directly for each service rendered
  - Managed Care involves the state paying Managed Care Organizations (MCOs) a fixed monthly rate per enrollee to manage and coordinate care and assume the claims risk for the rating period.
- Under fee-for-service, NC Medicaid had the ability to freeze/increase/decrease rates at any point in time. Fee-for-service required a State Plan Amendment to implement any rate increases/decreases, and there were no annual, required inflationary increases built into the State Plan except for hospitals and nursing facilities indexing.
  - In fact, some providers in the NC Medicaid program have had rates frozen since the recession in 2012.
  - At the same time, services paid based on cost, such as pharmacy and outpatient services, are more subject to inflationary increases, rather than a set fee schedule.
  - Additionally, in instances where utilization is diminished, the State directly benefits from this in the form of reduced claims costs.

Fee-for-Service vs Managed Care

- Under managed care, per federal law, the health plans must be paid actuarially sound rates. To comply with this, there are necessary increases built into managed care rates to include health care inflation and certain utilization trends based on prior year's actual utilization.
  - Because there are required increases built into managed care rates to maintain actuarial soundness, and because we have expanded managed care coverage of our population (SP, TP, CFSP, etc.), the overall expenditures for the program are expected to increase as inflation and utilization increase.
  - Note that as part of managed care development, each year our actuaries also consider expected downward impacts to utilization to appropriately consider how managed care companies may be able to direct services to more efficient levels of care (e.g., emergency room and inpatient avoidance).
  - Managed care companies do have incentives to further curb utilization beyond actuarial expectations, but any of this incremental utilization savings accrue to them in the first year and not the state. There is the potential for capitation rates for future years to decrease based on this diminished utilization, but it would need to be greater than overall inflation and utilization increases in other services to yield noticeable savings to the state.
  - North Carolina's Managed Care Companies are also required to pay the state's insurance premium tax of 1.9%. This tax is built into the capitation rates which is then paid out of the Medicaid budget. The revenue, however, benefits the state general fund, unlike hospital and other provider taxes which are used to offset Medicaid program costs.
- Projections of the impact of managed care in North Carolina Medicaid were shared in 2019 and can be found at https://medicaid.ncdhhs.gov/ncga-report-7year-forecast-final-20190409/download.