NC Department of Health and Human Services
Division of Health Benefits (NC Medicaid)

Continuous Coverage Unwinding (CCU) and Medicaid Expansion Program Overview

Melanie Bush
Chief Operating Officer, NC Medicaid

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MEDICAID CONTINUOUS COVERAGE UNWINDING

COVID-19 Federal Public Health Emergency (PHE)

2023 Consolidated Appropriations Act (Omnibus Bill)

- Signed into law Dec. 29, 2022
- Removed the continuous coverage requirement from the federal COVID-19 PHE
  - As of April 1, 2023, state Medicaid programs are no longer required to maintain continuous coverage for beneficiaries
- Includes a new requirement to contact individuals using more than one modality prior to termination
  - A beneficiary's Medicaid cannot be terminated due to mail being returned as undeliverable. State Medicaid programs are required to make a good-faith effort to find the person.
- Requires one year of continuous coverage for kids on Medicaid and NC Health Choice (no change from NC Medicaid's current policy)
- Permanently extended the 12-month postpartum coverage option.

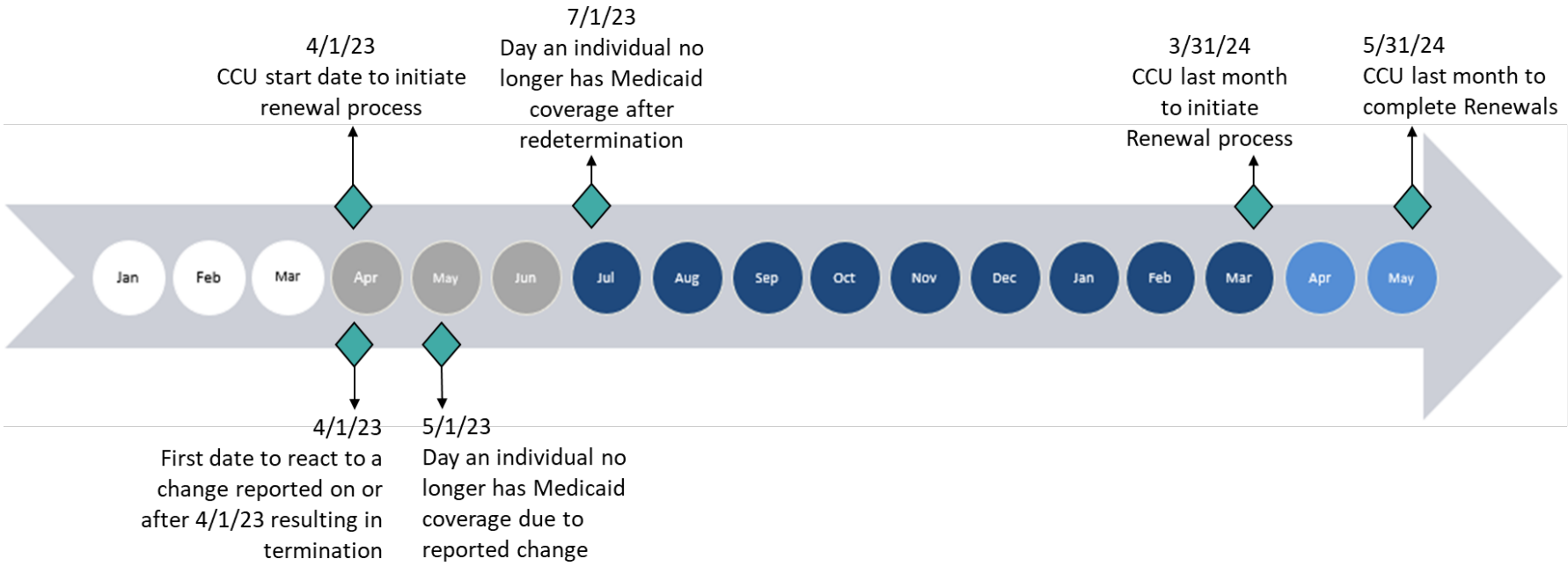
NC Medicaid's Continuous Coverage Unwinding

NC Medicaid began the renewal (recertification) process for Medicaid beneficiaries April 1, 2023. (The unwinding)

- Recertifications will be completed over the next 12 months, as beneficiaries are up for renewal
  - During renewal, the beneficiary's local Department of Social Services (DSS) will use information they have on file to decide if they or their family member(s) still qualify for NC Medicaid
  - If the local DSS needs more information from a beneficiary to decide on coverage, they will send the beneficiary a renewal letter in the mail
- If a beneficiary is found ineligible for Medicaid, they will receive a letter with the following information:
  - The program being terminated or reduced
  - The decision made by DSS
  - Deadlines for responding
  - How to appeal the decision

Continuous Coverage Unwinding Timeline

Local Departments of Social Services have been completing recertifications throughout the PHE, however, coverage has not been terminated or reduced. North Carolina is using an age-based approach for recertifications during the unwinding period.



If a Beneficiary is Redetermined Ineligible

If a beneficiary loses their NC Medicaid eligibility during recertification their Medicaid coverage will end.

- Beneficiaries have the right to:
  - Appeal the decision. Beneficiaries have 60 days from the date of the termination letter to appeal.
  - Continue to receive benefits pending the fair hearing decision.*
- If a beneficiary no longer qualifies for Medicaid:
  - They may be able to buy a health plan through the federal Healthcare Marketplace and get help paying for it. healthcare.gov
  - Four out of five enrollees can find plans that cost less than $10 a month
  - Plans cover things like prescription drugs, doctor visits, urgent care, hospital visits and more

* If the resolution upholds the beneficiary's termination; the beneficiary may be required to pay for medical services received while the appeal was pending.

What Beneficiaries Can Do to Get Ready for Recertification

Update their contact information

Beneficiaries should make sure their local DSS has their current mailing address, phone number, email or other contact information.

With an enhanced ePASS account, beneficiaries can update their address and other information for Medicaid online without having to call or visit their local DSS.

Check their mail

Local DSS will mail beneficiaries a letter if they need to complete a renewal form to see if they still qualify for Medicaid.

Complete the renewal form (if they get one)

If a beneficiary receives a renewal form, they should fill out the form and return it to their local DSS right away to help avoid a gap in their Medicaid coverage.

Omnibus Bill Requirements - Returned Mail Condition

The “returned mail condition” requires states make a “good-faith effort” to contact an individual using “more than one modality” when returned mail is received in response to a request for information to complete a recertification.

Meeting the returned mail condition is a two-part requirement.

- Requirement 1: States must attempt to obtain up-to-date mailing addresses and additional contact information (e.g., phone number, email address) for ALL beneficiaries.
- Requirement 2: During the continuous coverage unwinding period, beneficiaries must be contacted through more than one modality prior to termination if returned mail is received. These modalities include:
  - Forwarding address on returned mail
  - Phone call
  - Email
  - SMS text message

To meet these requirements, Medicaid is conducting a targeted beneficiary outreach campaign during the unwinding period.

Targeted Outreach Efforts

Requirement 1 — Attempt to obtain up-to-date contact information for ALL beneficiaries.

Contact Modality	Description	Dates	Timing
Mass Text Messages	Update your contact information so you don't miss important updates from Medicaid. Use ePASS or contact your local DSS.	March 2023 – February 2024 Completed in batches based on the beneficiary's renewal due date.	Monthly; based on when the beneficiary is due for Medicaid recertification.
Robo Calls from EB			
Mass Emails			

This is in addition to direct mailings from health plans and the enrollment broker, social media, website, press releases, community presentations and webinars.

Targeted Outreach Efforts

Requirement 2 — Prior to termination of coverage, contact beneficiaries using more than one modality if returned mail is received.

Contact Method	Description	Dates	Timing
Texts, emails, and robo calls in response to a Renewal Form or Request for Information being sent	Your DSS needs information; Check your mail; Link to provide details on how to complete the recertification	April 2023 – March 2024	Weekly (upon generation of the Renewal form or Request for Information)
Mail returned Renewal Notice or Request for Information to Forwarding Address	Resend returned Renewal Notice or Request for Information if a forwarding address is provided	April 2023 – May 2024	As returned mail is received

Flexibilities and Other Efforts to Increase Automation/Save Time

Flexibility / Change	Description	Goal	Implementation Date
Change Reasonable Compatibility threshold from 10% to 20%	Attested income that is within 20% of electronic source income is Reasonably Compatible	Improve STP rates; Increase ex parté rates	January 2023
Straight-through MAGI Recertification Processing Statewide	System processes, approves, and sends renewal notices for some MAGI cases	Reduce caseworker touch on recertifications	January 2023
Update beneficiary address using NCOA or USPS info	Accept updates to beneficiary address from NCOA database and USPS in-state forwarding address without additional confirmation	Change of address from USPS forwarding address label or Enrollment Broker or Health Plan RM reports does not need further confirmation from beneficiary	March 2023
Updates to Case Selection Criteria for Straight-through MAGI Recertification Processing	Some case types that were not being selected for STP are now included	Increase automation	March 2023

Flexibilities and Other Efforts to Increase Automation/Save Time

Flexibility / Change	Description	Goal	Implementation Date
Renewal for individuals based on SNAP income	Auto-renew Medicaid benefits for someone with SNAP benefit started/renewed within the past 5 months	Increase automation during unwinding period	April 2023
Straight-through MAGI Application Processing	System processes, approves, and sends approval notice for some MAGI applications	Reduce caseworker touch on applications	April 2023

Resources

Medicaid recertification webpage medicaid.ncdhhs.gov/renew

Medicaid End of the PHE/CCU website medicaid.ncdhhs.gov/End-of-PHE

Medicaid recertification video English | Spanish

Medicaid recertification fact sheet English | Spanish

MEDICAID EXPANSION

What is Medicaid Expansion?

- Governor Cooper signed HB 76 into law on March 27, 2023. This is a historic moment for the health and wellbeing of our state
- Over 600,000 North Carolinians will gain access to health care coverage
- Medicaid Expansion in North Carolina increases eligible population to all adults aged 19-64 who have incomes up to 138% of the Federal Poverty Level
  - Single adults 19-64 who have incomes of approximately $20,000 each year
  - Parents with low incomes – for a family of 3, an annual income below about $34,000 each year
    - Prior to expansion the cutoff for parents is about $8,000 each year
- Same ways of getting care as existing Medicaid
- Same comprehensive benefits and copays as other non-disabled adults in Medicaid
- NCDHHS and other external stakeholders will partner together to drive implementation, outreach and engagement, and support our counties in this work

Who is Covered under Expansion?

Low-income parents
(above current coverage levels and with income less than $34,000 each year for a family of 3)

- Low-wage workers (agriculture, childcare, construction, etc.)
- Some veterans and their families

Low-income childless adults
(with income less than $20,000 per year for a single adult)

- Children who age out of Medicaid
- Women who would be covered if they were pregnant

Estimated Eligible Beneficiaries

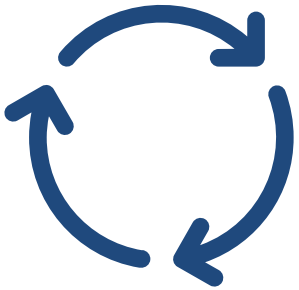
- More than **600,000 individuals are estimated to be covered under Medicaid Expansion** by the end of the second year. This includes:
  - **300,000** expansion enrollees moved from Family Planning benefit by the end of the first year
  - **100,000** beneficiaries who may have lost full Medicaid coverage during recertification in absence of expansion
  - **200,000** expansion eligible individuals not currently enrolled in Medicaid statewide expected to enroll in the first two years
- Of the estimated 300,000 expansion enrollees moved from the Family Planning benefit by the end of the first year:
  - **92%** of these beneficiaries are estimated to be enrolled in a **Standard Plan**
  - **7-8%** of these beneficiaries are estimated to be enrolled in a **Tailored Plan, or NC Medicaid Direct** prior to the Tailored Plan launch*
  - **Less than 1%** of these beneficiaries are estimated to be enrolled in the **Tribal Option**
  - **Less than 1%** of these beneficiaries are estimated to be enrolled in **NC Medicaid Direct**

*Some of the beneficiaries estimated to be enrolled in a Tailored Plan may stay in NC Medicaid Direct after Tailored Plan launches due to other circumstances.

Note: These numbers are estimates and can vary from the final numbers at the time of Medicaid Expansion launch.

Intersection of CCU and Medicaid Expansion

- As beneficiaries complete recertifications, they may have incomes above the parent/caretaker income level (~43% FPL) that they did not have during the PHE
- Beneficiaries who may be eligible for Expansion (incomes <138% FPL) will likely qualify for our limited Family Planning Only benefit (incomes <195% FPL)



  - At Expansion launch date, FP Only beneficiaries will be evaluated for Medicaid Expansion and moved to the Expansion eligibility group on Day 1 of Medicaid Expansion
  - Estimate up to 300,000 beneficiaries may be eligible on Day 1

- Post Expansion launch, individuals will be screened for eligibility for all available programs, including Expansion

QUESTIONS