

From Continuous Coverage to Medicaid Expansion: North Carolina's Changing Public Payer Landscape

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During the COVID-19 pandemic, people who may have otherwise lost Medicaid coverage kept it without the need to reapply annually. In 2023, this continuous coverage began to unwind just as North Carolina prepared to expand Medicaid. This issue of the *North Carolina Medical Journal* tracks the evolution of the state's public payer landscape in unprecedented times of change, with data, analysis, and personal experiences from public health, philanthropy, clinicians, and Medicaid members.

North Carolina has made unprecedented impacts over the past three years in the public payer landscape (known colloquially as NC Medicaid and officially as the North Carolina Department of Health and Human Services [NCDHHS] Division of Health Benefits). Ongoing notable modernizations scheduled to continue over the next 36 months include the launch of the NC Medicaid Managed Care Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan (Tailored Plan), procurement and launch of the Children and Families Specialty Plan, and the 1115 Demonstration Waiver Renewal.

How did we get to today? In 2015, the North Carolina legislature enacted Session Law 2015-245 to “transform” Medicaid [1]. Under the leadership of then-NCDHHS Secretary Mandy Cohen, the state built the framework for our unique approach to Medicaid managed care [2]. Only months prior to the scheduled launch of Medicaid managed care, the COVID-19 pandemic took center stage, disrupting health care as we knew it when Governor Roy Cooper issued Executive Order 121, the stay-at-home order, on March 30, 2020 [3].

Despite the pandemic, managed care launched on July 1, 2021, impacting nearly 1.6 million beneficiaries and the 100,000+ providers enrolled in NC Medicaid. During this monumental shift to managed care, the pandemic raged on; with an uncertain “end date,” NC Medicaid began identifying aspects of temporary policy flexibilities that would remain in permanent policy—particularly those flexibilities tied to state authorities, such as telehealth [4]. Juggling the inevitable challenges inherent in a move to managed care, the whole field of health care providers and payers balanced this tremendous change in a major payer while navigating

unprecedented workforce shifts caused by the pandemic.

During this same time, enrollment in NC Medicaid climbed due to the federal mandate to provide continuous coverage as a component of the Families First Coronavirus Response Act (FFCRA) [5], reaching a peak of 2.97 million members in April 2023 [6]. Then, in a bipartisan vote, the North Carolina General Assembly enacted Medicaid expansion on March 27, 2023 [7], only days before counties began the process of re-enrollment as part of continuous coverage unwinding. Subsequently, tens of thousands of members began losing NC Medicaid coverage each month beginning in July 2023 [8]. With the fall 2023 state budget bill, the wheels to launch expansion went into motion. Through a feat of rapid planning, coordination, and implementation on the part of the entire state, close to 260,000 members moved from the limited Family Planning benefit into full Medicaid coverage on December 1, 2023 [9].

In This Issue

In this edition of the *NCMJ*, you will read about people enrolled in Medicaid in a variety of ways: as “members,” “beneficiaries,” “individuals,” and “enrollees.” We unpack some of the effects of the changing public payer landscape in North Carolina, from managed care launch, to the public health emergency coverage unwinding, to the launch of expansion, from a variety of viewpoints. All these changes allowed the NC Medicaid program to mature and develop in positive ways; simultaneously, we must acknowledge the effects of a dramatically changing payor landscape on patients, providers, and programs.

The move to managed care in North Carolina brought significant changes to providers and members and had an immediate impact on the primary care field, which is particularly important given North Carolina's national reputation as a leader in primary care [10]. Dr. Tom Wroth,

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President of Community Care of North Carolina, and coauthors reflect on how the primary care space experienced, is reacting to, and is considering the future of managed care [11]. Notable positive effects of the 1115 Demonstration Waiver that brought managed care are the early impacts of the Healthy Opportunities Pilots (HOP), in which North Carolina General Assembly funding allowed Medicaid dollars to provide food, housing, transportation, and other services not traditionally covered by a public payer. Not only did this funding allow North Carolina to become one of the first states to support meeting unmet whole-person care needs in this way, it created scaffolding for community providers that have historically relied on donations and grants for the provision of these critical supports, establishing a more sustainable model. In this journal, Amanda Van Vleet, Deputy Director of Population Health at NC Medicaid, shares the early impacts of HOP and reflects on its first year [12]. A dispatch from our Western North Carolina pilot, written by authors from Dogwood Health Trust, describes the experience of leading this transformation on the ground [13].

Mental health needs have increased as a result of the pandemic, and this includes a worsening of outcomes tied to substance use disorders. In this journal you will see the evidence of these worsening impacts as well as the hope that Medicaid expansion brings. The impacts of the Substance Use Disorder waiver and the intentional efforts of NCDHHS to enhance integrated care in the venue of a public payer have long-reaching impacts, writes Kelly Crosbie, Director of the NCDHHS Division of Mental Health, Developmental Disabilities, and Substance Use Services [14]. Over the past several years, and throughout Medicaid transformation, NCDHHS has focused on behavioral health services, heightened with the leadership of Secretary Kody Kinsley.

Only months before the pandemic, NCDHHS launched a telehealth workgroup to modernize the meager virtual offerings of NC Medicaid, which was well behind other states. Early estimates were for a three-year process to shore up these services, but instead, in the blink of an eye, with a stay-at-home order issued by the governor, the state rapidly developed hundreds of policy modifications to allow as many people as possible to continue to receive care from home. As those benefits took hold, the next step in the journey was identifying what would stay in permanent NC Medicaid policy and what would need to return to baseline, disrupting the provider field yet again. Jessica Kuhn, Quality Measurement Lead in Program Evaluation at NC Medicaid, and coauthors discuss the aggressive evaluation established at the onset, as well as some of the learnings that are driving permanent decisions [15].

The Acute Hospital Care at Home program, launched by CMS to improve much-needed access to hospital beds at the height of the pandemic [16], is an example of rapid innovation, evaluation, and iteration. NCDHHS partnered with our state's hospitals to understand the merits of this model and help create bed access; the subsequent evaluation pro-

vided assessments for future coverage. While traditional studies of this model focused on Medicare and commercial populations, Dr. Arianna Keil, Chief Quality Officer for NC Medicaid, shares some of the results of the first analysis of implementing Acute Hospital Care at Home with a pure Medicaid population [17]. Unprecedented flexibilities were allowed by CMS during the public health emergency that left states to determine which services they had the ability, authority, and fiscal resources to continue. Deb Goda, Olmstead Director in the Office of the NCDHHS Secretary, and LaCosta Parker, IDD Clinical Consultant, describe the impact of the waiver flexibilities in our state, particularly on vulnerable populations [18]. This journal tells important stories of utilization of these resources, the impact on families, and ongoing maturation of coverage, and we hear directly from families who experienced these waiver flexibilities firsthand [19].

While all these changes were underway at the state level, counties were pivoting their resources to respond first to COVID-19, then managed care, then the continuous coverage unwinding, and most recently expansion. Plagued by the same workforce shortages seen across the country, North Carolina counties had to reconnect with 3 million Medicaid members and begin the process of reconsidering them for coverage. Dr. Emma Sandoe, Deputy Director of Medicaid Policy in the Division of Health Benefits, dives deeper into this overlap and its impacts [20]. The state worked quickly to provide supports that had immediate and positive effects on both people and counties. This issue includes firsthand accounts from county leaders—Lisa Macon Harrison of Granville Vance Public Health and Joshua Swift of Forsyth County—about the challenges of this overlap and the hope they have for the future, as well as a piece from Deputy NC Medicaid Director Melanie Bush about strategies for supporting county departments of social services during this transitional time [21, 22].

Amid what might have felt to some like darkness came the light of Medicaid expansion, allowing over 600,000 people access to full health care benefits. Reducing the impact on county Departments of Social Services and enhancing the efficiency of enrollment became a driving force at the state. Meanwhile, once again, counties and safety-net providers had to rapidly shift their focus from the COVID-19 response and prepare for new processes, people, and demands. Leaders from two Federally Qualified Health Centers—Kim Schwartz of Roanoke Chowan Community Health Center and Pamela Tripp of CommWell Health—share how they have navigated this dramatic time [23]. As we move into expansion, a key question becomes how we will know if we were successful. The evaluation plan for expansion is described here by Melanie Luques and Sam Thompson of NC Medicaid [24]. As we pull the threads of so many overwhelming changes in a short period of time, how do we meaningfully seek to understand the positive and negative outcomes of this historic move?

As you read through this edition of the *North Carolina Medical Journal*, amid tectonic shifts in our public payer system, consider what is to come next:

- The launch of the Tailored Plans, legislated to occur no later than July 1, 2024 [25];
- The procurement and launch of the Children and Families Specialty Plan, legislated to occur no later than January 1, 2025 [25];
- The 1115 Demonstration Waiver renewal submitted to CMS in October of 2023, which requests the broadening of HOP across the state, continuous enrollment for children, and perhaps most transformative: bringing the justice-involved population into care months prior to their release from incarceration, in an effort to bridge the dangerous transition time and optimize the chance of successful community reentry [26].

Conclusion

This edition of the *North Carolina Medical Journal* is a snapshot of a moment in time in what will continue to be a changing and challenging landscape. It is my hope that the reader considers the herculean efforts of the Medicaid program in concert with sister divisions in the NCDHHS, state and county government, and our many community partners, and the progress we are all making together toward a healthier North Carolina.

As a point of personal privilege, as this journal goes to print I will be wrapping up my fifth year as the Chief Medical Officer for NC Medicaid. One of the great opportunities of my professional life has been the commute from the far mountains of North Carolina across the state to the capital to help lead through what has been a tumultuous and transformative time in the history of NC Medicaid.

This edition of the journal only scratches the surface of the incredible work that has happened in recent history, with a hyperfocus on health equity as a guiding star, as North Carolina has responded to public health crises, dramatic policy changes, and systematic modifications to an entrenched public payer system. For every one of the highlighted items in this edition, there are literally dozens of other equally significant changes and impacts. While that means tremendous work on the part of hundreds of state employees, the exponential impact on the “boots on the ground” providers and local systems of care must be considered. We must continue to work to find the balance between implementation of programmatic modernizations and systematic impacts that risk overwhelm and paralysis if not undertaken with the same degree of exceptional care that you will learn about in this journal. NCMJ

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