Q&A: Continuous Coverage Unwinding and Medicaid Expansion on the Ground in Two North Carolina Counties

Interview conducted by Shannon Dowler and Kaitlin Ugolik Phillips

Introduction

The COVID-19 pandemic resulted in many changes in the way care was delivered across North Carolina. At the county level, public health became more prominent than ever, serving more people in new ways while adapting to the evolving public health emergency.

After three years of continuous Medicaid coverage as permitted by COVID-19-related waivers, in 2023 counties had to begin redeterminations of eligibility, "unwinding" this continuous coverage. As unwinding and eligibility determination continues, Medicaid expansion has begun, and county public health leaders are navigating uncertain but exciting waters.

In this Q&A, two North Carolina public health leaders—**Lisa Macon Harrison**, MPH, of Granville Vance Public Health, and **Joshua Swift**, MPH, of Forsyth County Department of Public Health, share their experiences, concerns, and hopes for the future.

NCMJ: What was your biggest concern with continuous coverage unwinding, and how has it gone in your county?

Lisa Macon Harrison: *There is still a lot of curiosity about how it's going to affect our management support and clinic support teams as they assist people to get signed back up for Medicaid if they became part of the unwinding. I also understand there may not have been the intention to move as many people off the Medicaid roles as happened. HHS reported many disenrollments were glitches in the computer system [1]. It's just a matter of managing the unknown.*

It's hard to know how it's gone so far, because where people register for Medicaid is not in local health departments, it's in Departments of Social Services, and we haven't modernized enough the process of enrolling for Medicaid to be able to keep our finger on the pulse of what's happening in real time.

Joshua Swift: *Our DSS is just across the parking lot from us, and they're trying to staff up. We're in a consolidated agency, all under health and human services, which happened a year and a half before COVID. So, we were just dipping our toe in the water of integration and then the pandemic happened, so we're still trying to learn how to work together and co-locate resources. I do know for us the churn was greatest among children, especially Hispanic children. If it's confusing for us at times as health professionals, I can't imagine how this impacts individuals.*

NCMJ: What's the biggest challenge you have encountered when it comes to individuals?

Harrison: *We got a Kate B. Reynolds grant to be able to advocate for the individuals who have or need Medicaid to better understand how to choose from the prepaid health plans. We've conducted a lot of interviews with our patients and with people in the parking lots of our local Departments of Social Services. When we ask people who have Medicaid, what prepaid health plan they chose and what benefits it has, they often don't know that language right there. We're trying to figure out how, in public health, we can better help people understand what their choices are, and what benefits come with those choices. And I think people are happy to have access to Medicaid. But beyond that, the knowledge about those differences is just really challenging.*

Swift: *Even those who were not rolled off are still trying to learn what those benefits are, and it depends on what part of the state they're in, which plans they have access to. That's still a new concept, much less with this unwinding. You just find out that your situation has changed so you're in uncharted waters.*

NCMJ: If you could wave a magic wand and do it better or differently the next time, how you would approach it differently?

Harrison: *The question I have gotten from my leadership team is, 'Are there other states that have privatized Medicaid that chose as many contracted agencies as North Carolina did?' We have five prepaid health plans for Medicaid, and then we have six managed care organizations for Tailored Plans. So, our local health department folks are managing 11 different points of contact and administrative burden. An interesting 30-minute conversation ensued after that about the patients who are attributed*

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Address correspondence to Kaitlin Ugolik Phillips, NCMJ (ncmedj@nciom.org).

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to each safety-net provider, because safety nets are not allowed to limit the number of people each prepaid health plan provides for us. We want to serve as many patients as possible, that is a value, and that is a service we're committed to doing. And also in this new value-based care world, public health departments and safety nets are penalized because the denominator, or the number of people who are attributed to us as assigned patients, are so numerous. Sometimes they're not our patients, and yet they go into our denominator for whether or not we're paid for quality measures and follow-up.

It's just an interesting, challenging time. We're all learning how to communicate with prepaid health plans, how to communicate with the state and Medicaid, how to communicate with the ombudsman, how to communicate with the patients themselves about what's working and what's not, and it's an incredibly complex natural experiment.

Swift: *I don't have anything to add, other than: let's not do this again. Let's make it simpler, not harder, if we do have to.*

NCMJ: Now, here comes Medicaid expansion. What will be the impact on local counties? And with these things going on at the same time, how are you approaching that in your locality?

Swift: *One day at a time. We don't do primary care, but we have an adult and children dental clinic, and in our family planning clinic we're anticipating some uptick there. I think we're looking at possibly 40,000 or 50,000 people in Forsyth County who could now be eligible. But I even have questions: when you just look at the Medicaid eligibility, I don't have the numbers in front of me, but if you're a single person and making $12 or $13 an hour for 40 hours a week you would be ineligible. More people are now eligible, which is great, but you'll still have that problem of making too much to be on Medicaid but too little to thrive, and then you have that benefits cliff where individuals maybe get a promotion, they get a raise, and now they're not eligible. But we are hopeful. There will be more people with access to care, and it will be better for our whole community.*

Harrison: *I think North Carolina still has to figure out a little bit more of a comprehensive approach to buying health, and that buying health doesn't just mean, in a value-based system, addressing individual payment options for social determinants of health. That was a good start. What we need to also acknowledge is, local health departments are uniquely positioned to help make communities healthier with environmental and policy changes and with prevention and population health. We manage the population of the counties and communities we serve as a whole, whether or not they have insurance. So, if we don't acknowledge the local health department role in how we make North Carolina community members healthier in our system of Medicaid, we are not doing all we could do.*

Part of what the combination of the NCIOM Future of Local Public Health Task Force recommendations and ARPA workforce dollars have done is to make space to think about the health department of 2030 and how we get there [2]. What do we need to do our very best work as we evolve? I think it's an incredibly exciting time to think about how we pay for foundational capabilities to be up, running, and moving forward as effectively as possible by 2030. They have made really good decisions in some other states to be innovative and invest in infrastructure, in workforce, in training, and in ensuring that people have the tools they need to make our communities healthier, because that makes our economy healthier.

Josh and I have colleagues who are just managing complexity all the time, and we're just trying to make sure we're at the next thing and helping the next person and the next staff member and doing the next report for the next grant. So, it's super hard to make that space that the NCIOM task force helped us make to say, 'Let's really be thoughtful. What do we really need? How do we really get to a better place in the next five or six years?'

NCMJ: Is there anything else that you would like to add?

Swift: *Mine and Lisa's health departments are different, and we are probably not three hours apart. And between us, there are probably seven or eight health departments, and we're all doing it a little bit differently. We value having all the safety nets, free clinics, FQHCs, and health departments we need in North Carolina doing the good work that they do in community. But it is a very lopsided funding mechanism that we have right now, and there is a great disparity across rural and urban.*

I've been a health director in three counties, and then the deputy health director in another. In New Hanover County we were focused on hurricane preparedness, but we didn't need primary care because there's a large FQHC three blocks down the street. Caldwell County—mountain, rural—we had primary care and animal control both within the health department. In Winston-Salem where it's more urban, we had community violence intervention.

We have public health, we just need to fund it. The worst thing I've seen is when we have a program that's been around for a few decades and it needs to do better with metrics and measurement and messaging, but there is a constant rebuild, maintain, tear down. You can't get anywhere if you're trying to rebuild every few decades.

Harrison: *I think it's important for people to understand that fee-for-service Medicaid dollars are only one way Medicaid helps support local health departments. There's this notion that we've expanded Medicaid, we're putting people who have lost coverage back on to Medicaid, so surely that will help local health departments. But just trying to offer fee for service for more patients also increases our cost at the local level to provide those additional services and it doesn't necessarily give us a tremendous increase in revenue. Local hospitals are getting millions of dollars because we're expanding Medicaid and they might need more capacity to serve more patients. Local health departments are not. We're struggling mightily trying to learn this new language, trying to figure out where we have the power to negotiate rates and where we don't, whereas before we've*

never had to have that skill with Medicaid.

It's really important that our state and federal partners and our PHP [prepaid health plan] partners all understand that local public health is the connection with the community on the ground at the local level. We've got to get better at that communication that we are that last mile of public health and community and we have long-standing, trusted relationships. Public health plays such a role at the local level to make health better, and that isn't being tapped into or recognized. We have a long way to go before we get that right across our system. I have confidence we'll get there, especially in North Carolina. We're good at figuring these things out and being innovative. NCMJ

References

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