NC Medicaid 101

Gina Hamilton, Associate Director, Policy/County Operations
Eva Fulcher, Deputy Director of Member Operations

Agenda

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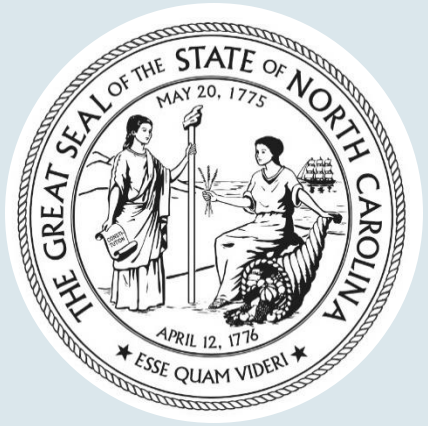
02 What are the benefits of Medicaid?

03 What happens after someone applies?

04 What is Medicaid Managed Care?

05 What is Medicaid expansion?

06 Medicaid Top Ten



What is Medicaid?

What is Medicaid?

- Medicaid is a health insurance program for low-income individuals and families who cannot afford health care costs. They must meet certain financial and non-financial criteria to be eligible to receive Medicaid.
- Like any other medical insurance, Medicaid pays for medically related expenses for individuals who are eligible to receive benefits.
- The goal of Medicaid is to assist individuals in getting quality care to help promote a long and healthy life.

Administering NC Medicaid

- Medicaid policy is governed by Federal and State regulations.
- NCDHHS' Division of Health Benefits (DHB) supervises the programs within guidelines set by federal and state laws.
- Local Departments of Social Services are responsible for administering the programs and determining eligibility for beneficiaries.

General Eligibility Criteria

- Be a resident of North Carolina.
- Be a US Citizen or have a qualified immigration status.
    - Non-US Citizens or people without qualified immigration status may be able to get coverage for emergency services.
- Lawfully Residing individuals who are pregnant or under age 19 may qualify for full coverage
- Provide a Social Security Number (SSN) (or have applied for one).
    - Exception: Undocumented Immigrants

General Eligibility Criteria (cont.)

- Not be incarcerated or a resident of a public institution.
    - Medicaid adult incarcerated in state prison or institution for mental disease can be covered only for inpatient hospitalization services if they meet all other eligibility criteria.
    - Medicaid juveniles under age 21 and former foster care up to age 26 in any facility can be covered only for inpatient hospitalization services if they meet all other eligibility criteria
- Not be receiving Medicaid in another State.
- Meet financial / non-financial eligibility requirements.

Medicaid Categories & Classification Groups

- Medicaid is divided into two categories:
  - **Family & Children's Medicaid** (also known as Modified Adjusted Gross Income (MAGI) Medicaid).
  - **Medical Assistance for Aged, Blind, and Disabled** (also known as non-MAGI or "Adult" Medicaid).
- Medicaid Classifications are:
  - **Categorically Needy (CN)** – provides full coverage for people whose income is below allowable limits
  - **Medically Needy (MN)** – also provides full coverage; allows people with higher incomes to meet a deductible to qualify (NC is one of the few States that offers this program, also known as spend down.)

Medicaid Programs

MAGI / Family & Children's		Non-MAGI	
Medical Assistance for Families (MAF)	Full coverage for children < 21, pregnant women, and caretakers of children under 18	**Medical Assistance for the Aged (MAA)**	Full coverage for individuals 65 and older
Medical Assistance for Infants and Children (MIC)	Full coverage for children < 19	**Medical Assistance for the Blind (MAB)***	Full coverage for individuals who meet Social Security's definition of blindness
Medicaid for Pregnant Women (MPW)	Full coverage for pregnant women during pregnancy and 12 months postpartum	**Medical Assistance for the Disabled (MAD)***	Full coverage for individuals < 65 who meet Social Security's definition of disability
Breast and Cervical Cancer Medicaid (BCCM)	Full coverage for women 18 through 64 with breast or cervical cancer	**Qualified Medicare Beneficiaries (MQB)**	Limited coverage that assists with Medicare premiums and/or co-pays and deductibles
Adoption Subsidy / Foster Care / State Foster Home / Former Foster Care Medicaid	Full coverage for a child with adoption assistance or in foster care or formerly in foster care in NC		
Medicaid expansion (MXP) – NEW!	Full coverage for people aged 19 through 64		
Family Planning Program (FPP)	Limited coverage for family planning services; no age restriction		

**Individuals who have not already been determined disabled or blind must be determined as such through Disability Determination Services in Raleigh to be eligible for these programs.*

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Income Rules for MAGI*

Countable	Non-Countable
• Wages • Unemployment benefits • Pension and annuities • Income from business or personal services • Interest • Alimony received • Social Security benefits • Foreign earned income • Lump sum in the month received	• Child Support • Veteran's Benefits • Gifts and inheritances • Worker's Compensation • Scholarships, awards, fellowship grants used for educational expenses • Certain Native American and Alaska Native income • Salary deferrals

Only **taxable income** is counted under MAGI rules

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*This is not an exhaustive list.

Income Rules for MAGI: Whose Income is Considered?

- MAGI uses a series of questions related to whether the applicant is a
  - Tax filer,
  - Tax dependent, or
  - Non-filer

This is how we establish the **MAGI household**.

- Based upon that household, countable income is determined.
- There are exceptions to including someone in the MAGI household (e.g., if the person is claimed by someone other than a spouse or parent.)

Income Rules for non-MAGI*

Countable	Non-Countable
• Wages • Unemployment benefits • Self employment • Child support received • Alimony received • Social Security benefits • Retirement benefits • VA Compensation	• SSI • Work First or Food & Nutrition benefit • Tax credits • Relocation payments • Vocational Rehabilitation payments • Grant / scholarship / fellowship

Earned and Unearned income (whether taxable or not) is counted under non-MAGI rules

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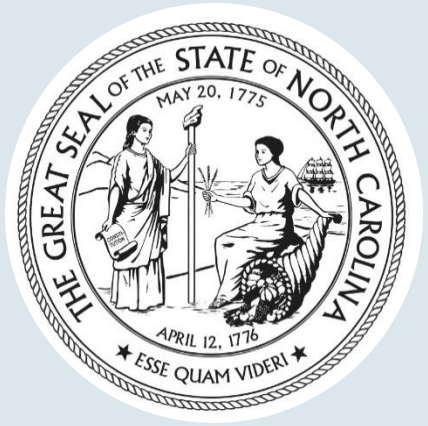
*This is not an exhaustive list.

Income Rules for non-MAGI: Whose Income is Considered?

- Countable income is based on financial responsibility of whomever's income you are determining.
  - Spouse for spouse
  - Parent for child (under age 21)
  - Some exceptions:
    - LTC, CAP, PACE
    - Individuals receiving SSI



What are the benefits of Medicaid?

Medicaid Covered Services

Medicaid covers most health services, including, but not limited to:

- **primary care** so you can go to a doctor for a check-up or when you are not feeling well
- **hospital services** when you need to stay overnight (inpatient) or when you can go home the same day (outpatient)
- **maternity and postpartum care** if you are pregnant and after giving birth
- **vision and hearing services**
- **prescription drug benefits** to pay for your medicines
- **behavioral health**
- **preventive** and wellness services
- **dental** and oral health services
- **medical-related devices** and other therapies

Medicaid Co-Pays

How much do people pay in monthly premiums and copays?

You do not have to pay any monthly premiums (exception: HCWD). Medicaid pays the cost for most health care services. The highest copay is $4 and that is only required for some services.

There are no **NC Medicaid copays** for:

- Beneficiaries under age 21
- Beneficiaries who get hospice care
- Beneficiaries enrolled in LTSS services
- Federally recognized tribal members or services from IHS facilities
- Beneficiaries who are pregnant including prenatal, childbirth and postpartum costs
- North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) or Family Planning beneficiaries
- People living in an institution who get coverage for cost of care
- Children/youth in foster care
- Innovations, TBI, CAP/C, CAP/DA waiver enrollees
- Behavioral health, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI) services
- Prevention services and antiretroviral drugs

Service	Copay
Chiropractic visits Doctor visits Non-emergency and emergency department visits Optometrist and optical visits Outpatient visits Podiatrist visits Dental Services	$4 per visit
Generic and brand prescriptions	$4 per prescription

Long Term Services and Supports (LTSS)

Some Medicaid beneficiaries may require a higher level of care or additional services. Those services may be provided under one of the following:

- **Long-Term Care (LTC)** – covers medically necessary nursing home care for a Medicaid beneficiary in a nursing home or intermediate care facility (ICF)
- **Community Alternatives Program for Disabled Adults (CAP-DA)** – a waiver program providing a cost-effective alternative to institutionalization for a Medicaid beneficiary who is medically fragile and at risk for institutionalization
- **Community Alternatives Program for Children (CAP-C)** – provides home and community-based services to children at risk for institutionalization in a nursing home
- **Program of All-Inclusive Care for the Elderly (PACE)** – a managed care program for adults 55 and older (most are dually eligible for Medicaid and Medicare)
- **Innovations Waiver** – designed to meet the needs of individuals with Intellectual or Developmental Disabilities (I/DD) who prefer LTSS in their home rather than an institution
- **TBI Waiver** – available in Wake, Durham, Johnston, and Cumberland Counties for people who experience a traumatic brain injury (TBI) on or after their 22nd birthday

All of these programs have a resource limit and are subject to transfer of assets evaluations.

Did you know about…

Auto Newborn Coverage?

Children born to a mother who is receiving full coverage Medicaid at the time of birth are automatically eligible. Hospitals submit referrals to the DSS for these babies using ePASS.

Emergency Services Medicaid?

Individuals who do not qualify for Medicaid due to citizenship or immigration status may be able to get health care costs covered for a medical emergency.

Healthcare for the Working Disabled (HCWD)?

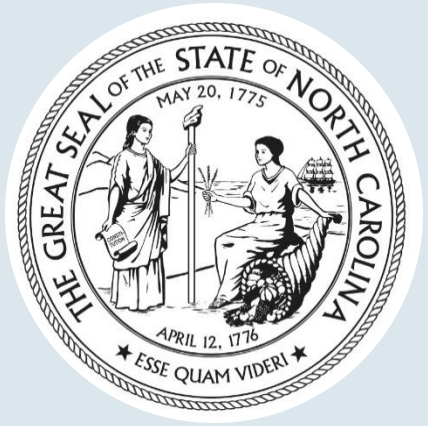
Full coverage for workers with disabilities aged 16 through 64. Requires an annual enrollment fee and beneficiaries may need to pay a monthly premium.

Retroactive Coverage?

You can apply for 1, 2, and/or 3 months of retroactive Medicaid coverage when you submit an application if you have medical bills to pay from those prior months.

Non-Emergency Medicaid Transportation (NEMT)?

Medicaid Transportation provides Medicaid beneficiaries with rides (or reimbursement for transportation) to and from appointments for Medicaid covered services provided by an enrolled Medicaid provider.



What happens after someone applies?

Pathways to Medicaid

ePASS Citizen Portal

- Person submits an application on the self-service ePASS portal.
- Application is transferred to NC FAST for processing by a caseworker.

Hospital Worker

- Hospital worker submits newborn referral if birth mother is on Medicaid.
- NC FAST will process the referral automatically or drop to a caseworker for further action.

DSS Caseworker

- DSS Caseworker takes an application in person (at the local DSS or an outpost location), over the phone, or via a paper application that was mailed or faxed to the DSS

NC FAST
North Carolina Families Accessing Services through Technology

HealthCare.gov

- Person submits an application on healthcare.gov (Federal marketplace website).
- Application is transferred to NC FAST for processing by a caseworker

Social Security Administration

- Information for Medicaid eligibility may also be transferred directly from Social Security Administration (SSA)
- Individuals receiving Supplemental Security Income are automatically eligible for Medicaid.

Processing and Eligibility Determination

Verification and Request for Information

- Information gathered on the application is used to determine an applicant's eligibility.
  - Some examples: relationships between household members, tax filing status, living arrangement, income, and resources.
- The NC FAST system calls electronic sources (e.g., SOLQis, The Work Number, DMV, DES) to verify this information.
- If information cannot be verified using electronic sources, a request for additional information/verification will be sent by mail to the applicant.

Eligibility Determination

- Once all information needed to determine eligibility has been received and verified, an eligibility caseworker will use NC FAST to determine each applicant's eligibility for Medicaid programs and determine their Managed Care status.
- This determination should be made within 45 days of the application being submitted (90 days if a disability determination must be made).
- If an applicant attests to having a disability, they must be evaluated by Disability Determination Services (DDS) before DSS can make an eligibility determination.

Notice of Eligibility

- Applicants must be sent a notice of eligibility determination once the application is dispositioned informing them of the outcome (eligible/ineligible) and reason (why am I eligible/ineligible) with supporting policy reference(s). This notice is sent to the applicant's mailing address (or electronically if they have signed up to receive e-notices).

After the Eligibility Determination

Approved	Denied
✓ • Receive approval notice • Receive a letter in the mail with healthcare options and health plan assignment (if applicable) • Receive Medicaid ID card* and health plan welcome packet (if applicable) • Benefits begin the first of the month in which you applied	✗ • Receive denial notice • Information is sent to healthcare.gov • You may still be able to get coverage through the marketplace

*Beneficiaries should present their Medicaid ID card at **each visit** to a healthcare provider or pharmacy. Providers & pharmacies should verify a beneficiary's Medicaid eligibility at **each visit**.

What is Medicaid Managed Care?

Key Partners and Their Roles

Beneficiaries	Are at the center of Medicaid Managed Care. Partners need to work together to support beneficiaries.
Community-based Agencies	Disseminate information to help educate the public on changes to Medicaid and provide feedback to DHHS from clients they serve.
Enrollment Broker	Acts as an unbiased, third-party entity to provide enrollment assistance and help in choosing a health plan and PCP; provides outreach & education to beneficiaries.
Health Plans	Provide health care and ensure related services are available to their members; inclusive of Prepaid Health Plans (PHPs) and the EBCI Tribal Option.
LME/MCOs	Local Management Entities / Managed Care Organizations manage the care of NC Medicaid beneficiaries who receive services for mental health, developmental disabilities or substance use disorders.
Local DSS	Determine Medicaid eligibility, update beneficiary information, and Medicaid eligibility case management.
NC FAST & NCTracks	Transmit beneficiary information; NC FAST remains the system of record for beneficiary information.
NC Medicaid	Provides NC Medicaid Direct supervision and oversight of health plans, local Departments of Social Services and other partners.
NC Medicaid Ombudsman	Provides information and education for beneficiaries; assists with issue resolution and referrals.
Providers	Contract with health plans; must be enrolled as a Medicaid provider.

Managed Care Terminology

Beneficiary	A person who is eligible for Medicaid.
EBCI Tribal Option	Health plan available to federally-recognized tribal members and others eligible for services through Indian Health Service (IHS).
Eligibility	Refers to whether a person qualifies for Medicaid. Eligible individuals may need to enroll in a health plan.
Enrollment	The process of joining a health plan that is responsible for that person's Medicaid health coverage.
Member	Once a beneficiary enrolls in a health plan.
NC Medicaid Direct	The fee-for-service model where the Department of Health and Human Services reimburses physicians and healthcare providers based on the number of services they provide, or the number of procedures they order.
NC Medicaid Managed Care	State contracts with insurance companies, called Prepaid Health Plans or PHPs (Health Plans). These insurance companies are paid a pre-determined set rate per person to provide all services, known as a capitated rate.
Standard Plan	Integrated physical & behavioral health services under NC Medicaid Managed Care.
Tailored Plans	Specialized plans for members with significant behavioral health needs and intellectual/developmental disabilities.

Managed Care Populations

NC Medicaid determines who must choose a health plan (mandatory), who cannot choose a health plan (excluded), and who has the option to choose a health plan (exempt).

Who must enroll in a Standard Plan?	Who may enroll in a Standard Plan?	Who cannot enroll in a Standard Plan?
MANDATORY	**EXEMPT**	**EXCLUDED**
• Most families and children • Pregnant women • People who are blind or disabled and not receiving Medicare **Note**: These groups must enroll in a Standard Plan unless exempt or excluded for any reason.	• Federally recognized tribal members or others eligible for services through Indian Health Service (IHS) • People who need services related to a mental health disorder, substance use disorder, intellectual/developmental disabilities (I/DD), or traumatic brain injury (TBI) **Note**: These groups may enroll in a Standard Plan unless excluded for any reason. **Note**: Beneficiaries with behavioral health needs may lose important services if they enroll in a Standard Plan.	• People receiving Family Planning Medicaid only • People who are medically needy • People participating in the Health Insurance Premium Payment (HIPP) program • People participating in the Program of All-Inclusive Care for the Elderly (PACE) • People receiving Refugee Medical Assistance • Children in foster care • Children receiving adoption assistance • Children receiving Community Alternatives Program for Children (CAP/C) services • People receiving Community Alternatives for Disabled Adults (CAP/DA) services • People receiving Medicaid AND Medicare • People receiving Innovations Waiver services • People receiving Traumatic Brain Injury (TBI) Waiver services

*Some beneficiaries are temporarily excluded and become mandatory later (e.g., when Tailored Plans launch).

What is the EBCI Tribal Option?

- The Eastern Band of Cherokee Indians (EBCI) Tribal Option is a health plan managed by the Cherokee Indian Hospital (CIHA) to meet the primary care coordination needs of federally-recognized tribal members and others eligible for services through Indian Health Service (IHS).
- The EBCI Tribal Option will has a network of primary care providers (PCPs) to choose from.
- Federally-recognized tribal members and IHS-eligible beneficiaries who live in the five-county region (Cherokee, Graham, Haywood, Jackson, or Swain County) are eligible.
- Federally-recognized tribal members and IHS-eligible beneficiaries who live within a reasonable distance from the five-county region (Buncombe, Clay, Henderson, Macon, Madison, or Transylvania County) may opt in.

When are Beneficiaries enrolled in Managed Care?

- New Applicants:
  - Enrollment is effective the month the application is dispositioned. (This may mean a portion of their eligibility period will be NC Medicaid Direct.)
- Beneficiaries with a Change of Circumstance impacting enrollment:
  - Enrollment change is effective the month following the change.
- At Recertification (redetermination):
  - Beneficiaries may choose to remain with current health plan or make a change.

Beneficiaries have a 90-day choice period in which to change health plans for any reason. The 90 days starts as of the effective date of enrollment.

Note: Exempt members (including federally-recognized tribal members) may change their health plan at any time for any reason.

Health Plan Enrollment Process

If a beneficiary must enroll in a health plan, NC Medicaid automatically enrolls them based on the criteria below:

- Geographic location
- Special population considerations (e.g., federally-recognized tribal member)
- Existing provider relationships and preference*
- Health plan assignments of family members
- Previous health plan enrollment
- Equitable health plan distribution

*Beneficiaries may choose a health plan preference at application.

After auto-enrollment occurs, the health plan assigns a primary care provider (PCP) to the beneficiary.

Standard Plans

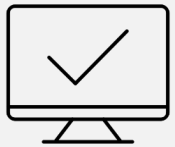
- All health plans offer the same base services. Some have added services. Each has its own network of doctors and professionals.
- The beneficiary's health plan ID card also has their Medicaid ID # and the name of their primary care provider.

WellCare	UnitedHealthcare Community Plan	HealthyBlue	AmeriHealth Caritas North Carolina	carolina complete health
1-866-799-5318 TTY: 711 wellcarenc.com 7 a.m. to 6 p.m., Monday through Saturday	**1-800-349-1855** TTY: 711 uhccommunityplan.com/northcarolina 7 a.m. to 6 p.m., Monday through Saturday	**1-844-594-5070** TTY: 711 healthybluenc.com 7 a.m. to 6 p.m., Monday through Saturday	**1-855-375-8811** TTY: 1-866-209-6421 amerihealthcaritasnc.com 24 hours a day, 7 days a week	**1-833-552-3876** TTY: 711 carolinacompletehealth.com 7 a.m. to 6 p.m., Monday through Saturday
				
Statewide (all 100 counties)	**Statewide** (all 100 counties)	**Statewide** (all 100 counties)	**Statewide** (all 100 counties)	**Only available in the counties listed below**

Carolina Complete Health is only available in these counties: Alamance, Alexander, Anson, Bladen, Brunswick, Cabarrus, Caswell, Catawba, Chatham, Cleveland, Columbus, Cumberland, Durham, Franklin, Gaston, Granville, Harnett, Hoke, Iredell, Johnston, Lee, Lincoln, Mecklenburg, Montgomery, Moore, Nash, New Hanover, Orange, Pender, Person, Richmond, Robeson, Rowan, Sampson, Scotland, Stanly, Union, Vance, Wake, Warren, Wilson

Answering Beneficiary Questions

Who to Contact



ABOUT ELIGIBILITY

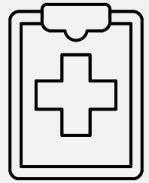
Contact their local DSS

Find contact information at ncdhhs.gov/localdss

ABOUT NC MEDICAID DIRECT BENEFITS AND CLAIMS

Call the Medicaid Contact Center toll free:

1-888-245-0179



ABOUT CHOOSING OR ENROLLING IN A HEALTH PLAN OR PCP

Contact the NC Medicaid Enrollment Broker ncmedicaidplans.gov (chat available)

Use the NC Medicaid Managed Care mobile app

Call 1-833-870-5500 (the call is free)

(TTY: 1-833-870-5588)

ABOUT NC MEDICAID MANAGED CARE HEALTH PLAN BENEFITS, REPLACEMENT CARDS, OR CHANGE IN PCP

Call their health plan

*EBCI Tribal Option members will contact DSS for replacement cards and change in PCP

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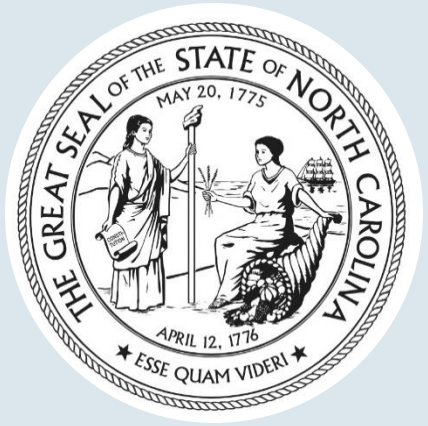


What is Medicaid expansion?

More North Carolinians can get health care coverage through Medicaid.

- North Carolina is providing health care coverage to more people through Medicaid.
- Medicaid now covers people ages 19 through 64 years with higher incomes.
- You may be able to get Medicaid even if you didn't qualify before.

More North Carolinians are now eligible.

People 19 through 64 years old with income up to **138% of the Federal Poverty Level.**

Household Size	Annual Income
Single Adults	$20,120 or less
Family of 2	$27,214 or less
Family of 3	$34,307 or less
Family of 4	$41,400 or less
Family of 5	$48,493 or less
Family of 6	$55,586 or less

Children, pregnant women, older adults, people with blindness and people with disabilities who meet the criteria below.

Group	Annual Income in 2023 *(rounded)*
Children	211% of Federal Poverty Level 1 - $30,800 2 - $41,600 3 - $52,500
Pregnant Women	196% of Federal Poverty Level 1 - $28,700 2 - $38,700 3 - $48,700
• Older Adults over 65 • People with blindness • People with disabilities *Asset limits also apply	100% of Federal Poverty Level 1 - $14,600 2 - $19,700

What if I previously had limited benefits through Family Planning Medicaid?

If you had Family Planning Medicaid before December 1, 2023 and met the new eligibility rules, you automatically receive full Medicaid coverage as of December 1, 2023. If you were automatically enrolled, you:

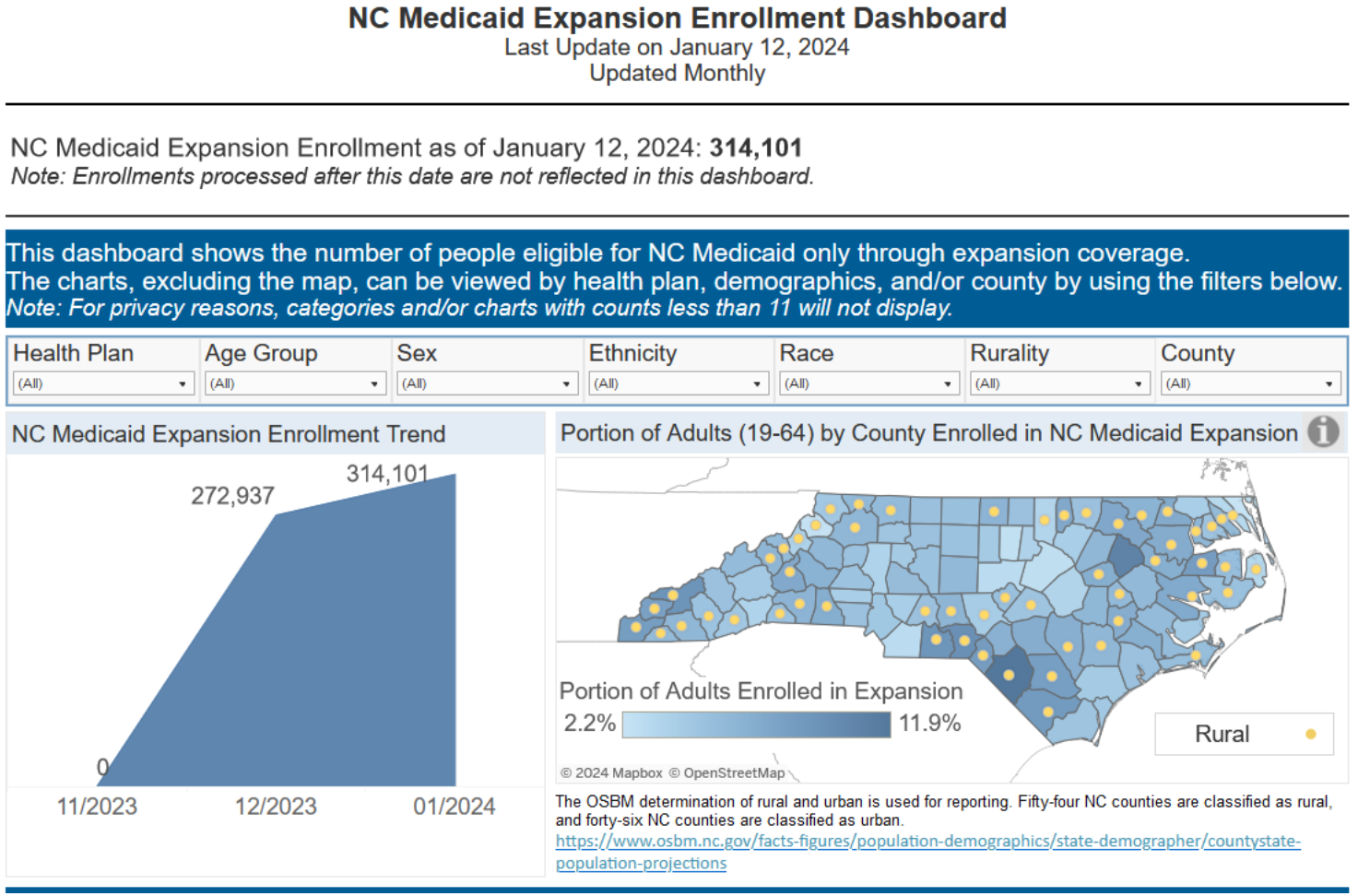
- Got a letter from your local Department of Social Services letting you know that you would start getting full Medicaid coverage.
- Were assigned a health plan. If you want to change it, you will have 90 days to pick a new one.
- Got a packet from your health plan with a new Medicaid ID card. Your ID card also has the name of your primary care doctor. You can change the doctor that was assigned by contacting your health plan.
- If you have health coverage through HealthCare.gov, you will need to cancel that plan.

Visit **Medicaid.nc.gov** to learn more

How many people will be covered because of Medicaid expansion?

Over 600,000 North Carolinians are estimated to be eligible because of Medicaid expansion. Enrollment information is available on our Medicaid expansion dashboard (updated monthly).

https://medicaid.ncdhhs.gov/reports/medicaid-expansion-dashboard

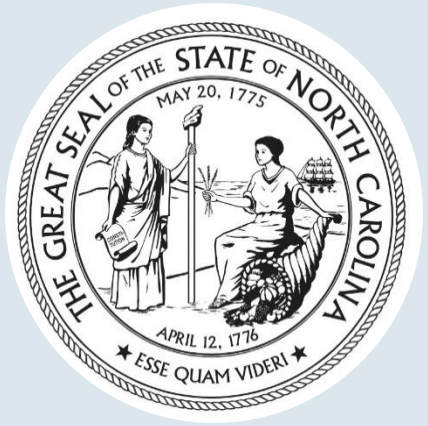


NC Medicaid Top Ten Takeaways

1. **NC Medicaid is healthcare**. Just like any other insurance program, it exists to cover the healthcare needs of North Carolinians.
2. **Anyone** can and should apply. Yes, you must meet eligibility rules. But no one should ever be discouraged from applying.
3. North Carolina has one of the more **robust Medicaid programs** in the nation.
4. Providers should **verify eligibility at every appointment**.
5. Medicaid **eligibility questions** should always be directed to a **local Department of Social Services**. You can find contact information for the DSS in your county here: https://www.ncdhhs.gov/localDSS
6. Medicaid is always the **payer of last resort**.
7. **No wrong door** – you can apply online, by phone, in-person, by fax/mail.
8. We contact our Medicaid beneficiaries at many points during the lifecycle of their case to **keep them informed** of important updates - using **texts, emails, phone calls, and letters**. It is important for beneficiaries to **keep their contact information updated** so they get this information.
9. NC has adopted most of the **e14 waivers** offered by CMS to help **maintain beneficiary access** to Medicaid.
10. We **expanded our program** to offer Medicaid to an additional **600,000+ individuals**.

NCMEDICAID FOR MORE PEOPLE

Learn more at Medicaid.nc.gov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THANK YOU!