MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: **North Carolina**
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: **Carmen Hooker Odom** Position/Title: **Secretary NC Department Health and Human Services**

Name: **L.Allen Dobson, Jr. MD** Position/Title: Assistant Secretary/**Director NC Division of Medical Assistance, DHHS**

Name: **Cinnamon H. Narron** Position/Title: **Coordinator, NCHC NC Division of Medical Assistance, DHHS**

Name: **Mark T. Benton** Position/Title: **Senior Deputy Director and Chief Operating Officer, NC Division of Medical Assistance, DHHS**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☒ A combination of both of the above.

Major elements of North Carolina's Title XXI Plan, North Carolina Health Choice for Children Program (NCHC) include:

Effective January 1, 2006, limit the eligibility for Title XXI to children age 6 through 18 with family income up to 200% of the federal poverty level and who do not qualify for Medicaid.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))** **NC state law expressly forbids any changes in the state plan until or unless the NC General Assembly has voted on the change in the plan.**

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

North Carolina's Title XXI Plan "will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20U.S.C. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. 6101-6107), which prohibits discrimination on the basis of age; (e) the Drug

Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) 523 and 527 of the Public Health Service act of 1912 (42 U.S.C. 290 dd-3 and 290-ee-3) as amended, relating to confidentiality of alcohol and drug abuse patients records; (h) Title VIII of the Civil Rights At of 1968 (42 U.S.C. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (I) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application."

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Plan Submitted: May 14, 1998
Plan Approved: July 14, 1998
Plan Effective Date: October 1, 1998

1st Amendment Submitted: October 21, 1998
1st Amendment Approved: January 15, 1999
1st Amendment Effective: September 30, 1998

2nd Amendment Submitted: March 26, 1999
2nd Amendment Approved: June 23, 1999
2nd Amendment Effective: March 12, 1999

3rd Amendment Submitted: July 12, 1999
3rd Amendment Approved: September 30, 1999
3rd Amendment Effective: July 1, 1999

4th Amendment Submitted: August 3, 2000
4th Amendment Approved: October 19, 2000
- a. **Native American Cost Sharing Exemption Effective:** May 1, 2000
- **b. Special Needs Children Effective:** October 1, 2000

5th Amendment Submitted: November 21, 2000
5th Amendment Approved: February 16, 2001
5th Amendment Effective: January 1, 2001

6th Amendment Submitted: October 12, 2001
6th Amendment Approved: January 9, 2002
6th Amendment Effective: October 8, 2001

Amended Consolidated Compliance Plan Submitted: March 1, 2005
Amended Consolidated Compliance Plan Approved: June 30, 2005

7th Amendment Effective (co-payment): February 1, 2004
7th Amendment Approved: August 24, 2001

8th Amendment Submitted: February 2006
8th Amendment Effective: January 1, 2006
8th Amendment Approved: May 10, 2006

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

North Carolina Health Choice for Children serves the entire state. Children who are enrolled in the program reside in all 100 counties. By age groups, fewer than 100 of these children are under age 1 at any given time because the Medicaid ceiling is 185% federal poverty level, hereinafter referred to as "fpl." (The remainder – those falling between 185% fpl and 200% fpl equals less than one percent of the population);

- **ages 2 to 5 years equals 19% of the population;**
- **ages 6 to 9 equals 29% of the population;**
- **ages 10 to 14 equals 34% of the population;**
- **ages 15-17 equals 15% of the population and 3 % of the children are age 18.**

Children age out of the program at the end of the month in which their 19th birthday occurs.

The State of North Carolina is ethnically diverse with a growing Asian and Hispanic populations. Historically, minority populations have higher rates of uninsured children. Specific outreach efforts to ethnic and racial groups are outlined in section 5. The effectiveness of these efforts can be seen in the table, "Race NCHC 2004," below:

The Current Population Survey, March 2005 Supplement estimated the number of children under age 19 at or below 200% of poverty to be 920,000. The number of children without health insurance was estimated at 173,000 or 7.6%.

The purpose of North Carolina's Title XXI plan is to serve as a vehicle to encourage parents to ensure that every child in the state has access to an ongoing system of preventive health care. The program is designed to provide comprehensive health care coverage for children of working families who make too much to qualify for Title XIX and too little to afford health insurance.

Here are the basic elements of North Carolina's Title XXI Plan:

1. ***The plan covers uninsured children age 6 through 18 whose family incomes do not exceed 200% of the federal poverty level***
2. ***Eligible children are enrolled in a non-entitlement program. This means that the amount of funds available to serve them determines how many can be served.***
3. ***In the event there are insufficient funds, new enrollments will be frozen 30 days following public notice.***
4. ***The benefits package is that provided through the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (also referred to as the State Employee's Health Plan or State Employees Health Plan) with additional preventive and maintenance dental, vision and hearing benefits. Benefits for Special Needs children are provided as follows: State Employees Health Plan administers and processes claims for children's acute medical care and other care of special needs children. Benefits for special needs children are as provided under the Medical Assistance Program except that no services for long-term care shall be provided for special needs children and except that services for respite care for special needs children are provided only under emergency circumstances.***
5. ***Families above 150% FPL pay copayments as follows: $1 for each generic prescription; $1 for each brand name prescription for which no generic is available and $10 for each brand name prescription with an available generic; $5 for each physician visit, clinic visit, dental and optometry visit except for preventive services (for which there is no copayment); $5 for outpatient hospital visits; and a $20 copayment for unnecessary emergency room use. For those below 150% FPL, there is a copayment for prescription drugs of $1 for all generics, $1 for brand names for which no generic is available and $3 for each brand name prescription with an available generic.***
6. ***There is an annual enrollment fee for those above 150% of the federal poverty level of $50 per child – with a $100 maximum for two or more children in the same family.***
7. ***Existing administrative structures and delivery systems are used.***
8. ***Extensive outreach campaigns have been conducted to ensure that eligible children are enrolled and that their health needs are met. Payment for their care has reduced some cost shifting to other payors. The state has seen some improvement in health outcomes.***
9. ***Enrollees whose income at reenrollment increases above 200% FPL (up to 225%) are allowed to buy into the program for one year at full cost. Because this is a costly option, few families that have***

selected this option.

****As defined by the State Employees Health Plan, for the emergency service definition please see: http://statehealthplan.state.nc.us/policies/PDFs/NCHC_AD0255.pdf***

Prior to the implementation of NC Health Choice, there was one public-private program in the state called the "Caring Program for Children." This program provided basic health services including well-child checkups, physician office visits, emergency room visits for illness or injury, outpatient surgery, diagnostic services, prescription drugs and a toll-free 24 hour nurse line. It did not cover inpatient hospitalization, mental health services, dental coverage, vision and hearing care. Operated through Blue Cross/Blue Shield of North Carolina (with public funds), this program was abolished on September 30, 1998, and the 6,000 – 8,000 children enrolled in the program were recommended for membership in NC Health Choice. Since the demise of the Caring Program for Children, there has been no other public/private partnership in the State.

There are several public safety net programs such as county health departments, federally qualified health centers, rural health centers, etc., that are integral components of the State's health care delivery system. NC Health Choice works diligently to develop and maintain strong working relationships with each of these entities, in addition to numerous public and private hospitals and family practice centers.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

North Carolina's outreach program is designed on a community-by-community basis. Each of the state's 100 counties has an outreach committee designed to identify and reach out to all uncovered children (both Medicaid and NC Health Choice) to find and enroll them.

To encourage both new and continuing Title XIX enrollment in the state of North Carolina:

- **Ex parte determinations are made for all children terminated from TANF or SSI for on-going Title XIX benefits to establish eligibility under other coverage groups.**
- **Twice annually, the State requires a review of Medically Needy cases in spend-down status.**
- **The State provides training to maternal and child care coordinators and Medicaid's Health Check Coordinators on eligibility requirements for children's coverage groups.**

The Division of Medical Assistance (DMA) publishes each year the income thresholds for Title XIX and XXI in provider bulletins to encourage providers to refer patients who may qualify to local departments of social services for application. Among the entities receiving this information are the Women, Infants and Children's nutrition program, local health departments, etc. DMA informs advocacy agencies of Title XIX and XXI income level changes annually so they may refer potential eligibles for application.

Eligibility workers are out-stationed in hospitals, Federally Qualified Health Centers, Rural Health Centers and public health agencies to accept the XIX and XXI joint application forms.

Outreach is carried out at the county level by each of the state's 100 outreach coalitions (one for each county). They are given material on the joint Health Check (Title XIX) and NC Health Choice for Children (Title XXI) through the State coordinated outreach effort. At both the state and county levels, every effort has been made to partner with the various children's advocacy groups, public schools, day care organizations, churches, business and industry, providers groups, etc. Links with the provider communities have also served as a direct link to uninsured patients to encourage enrollment and reenrollment in the program.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

There no longer exists a public-private partnership program in North Carolina since the Caring Program for Children was eliminated on September 30, 1998.

Parents of children who are not eligible for public programs are

urged to find private health insurance.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)* **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

North Carolina's outreach program for Title XIX and XXI children is combined in its Health Check/NC Health Choice for Children outreach effort conducted through the Division of Public Health and the section that manages the Title V program. This interaction has increased awareness of, and coordination among, all three programs. One goal of the combined outreach is to remove any stigma from any publicly offered health insurance coverage for children and to assure that the child's use of services is maximized. Currently North Carolina's outreach effort includes wellness and prevention messages to assist enrollees in using the program in a manner that maximizes the health of the children and minimizes unnecessary costs to the state and federal governments. The benefits of NC Health Choice are benchmarked in the Health Plan for State Employees and Teachers dependents. That plan - plus vision, dental, hearing and special needs to the Medicaid level (determined via the Title V staff) - constitutes the benefits of the program.

The state is addressing any potential "cliff effect" by a combination strategy of an annual enrollment fee and a one-year buy-in at full premium costs for enrollees whose family income increases above 200% FPL to 225% FPL. This is designed to serve as a "weaning" or transition period to private health care coverage.

During application processing, the existing Title XIX Eligibility Information System (EIS) is queried to ascertain if the child has Title XIX coverage or other insurance coverage. The application is simultaneously assessed for Title XIX eligibility and Title XXI eligibility and the child is enrolled in whichever program he or she is eligible to be enrolled.

Through outreach, the Department of Health and Human Services collaborates with and coordinates appropriate communications resources and activities between and among Title XXI and such ongoing programs and efforts as WIC, Maternal and Child Health Block Grant,

Children's Special Health Services, Smart Start and Head Start. NCDHHS also engages the participation of the private sector in providing no-cost or low-cost avenues for publicizing the Title XXI program in local communities statewide. These have included working with providers across the state to outreach to their patients who need the program and to solicit their input on the effective operation of the program.

The Robert Wood Johnson "Covering Kids and Families" funds, managed under the auspices of the NC Pediatric Society Foundation, is stressing reenrollment efforts, preventive health efforts and innovative uses of technology to prevent the inadvertent loss of home/mailing addresses of member children.

The Provider Task Force of NC Health Choice continually assesses both how the provider community (defined as primary care practitioners as well as representatives of vision, dental, hearing and mental health specialties) can assist in assuring both enrollment and reenrollment by families, and how to entice more providers into providing care to NC Health Choice patients. These efforts have included, but are not limited to: peer-to-peer visits among Health Choice and non Health Choice dentists, conversations among providers at specialty meetings, etc. Meetings with the office managers association have successfully ensured that "We take NC Health Choice" signs are posted in the doctor's office, and that office workers check enrollment dates on cards so that families can be reminded to reenroll. The Provider Task Force has also been successful in addressing certain gaps in service. One notable effort included the addition of dental sealants; fluoride varnish for children and pulpotomies and steel crowns as covered services.

The Governor's Commission on Children with Special Health Care Needs is charged with assessing and recommending improvements in the special needs services to all children in the state, with a particular attention being paid to NC Health Choice. The commission has examined the relationships between schools and health providers in the area of children with behavioral health care needs. They were responsible for recommending changes in residential care criteria and for assuring that special needs children were exempted from an existing period of uninsurance. The success of this amendment led to the removal of a period of uninsurance as an eligibility requirement for all NCHC children.

Other cooperative efforts have included the inclusion of NC Health Choice advertisements on the inside cover of WIC folders, and NC Health

Choice's role in a pilot program to enhance voluntary use of "health homes" for children.
These efforts have contributed to increased levels of cooperation and ownership in the program. More importantly, they have led to a provider/community network that is dedicated to the overall improvement and long-term existence of the program.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

The State of North Carolina provides health insurance benefits through a plan managed by the NCDHHS with health benefits provided through the Teachers and State Employees Comprehensive Major Medical Plan, from hereon referred to as the State Employees Health Plan - a program offering fee-for-service to any willing provider for indemnity health insurance. Benefits and claims processing are administered by the State Employees Health Plan, and eligibility is determined by county departments of social service (DSS). Upon determination of eligibility (and receipt of any applicable enrollment fee), the county Medicaid eligibility specialist enters the member's information into the statewide Eligibility Information System (EIS). Through the Division of Medical Assistance (DMA), EIS then electronically forwards Title XXI eligibility information to the State Employees Health Plan and sends notification of eligibility to families. The State Employees Health Plan then sends families information about the Plan of Benefits and processes claims.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

The same utilization controls used in the State Employees Health Plan are also used in the Title XXI program. The State Employees Health Plan is established and operated under North Carolina General Statute 135-37 through 135-41.3. Medical necessity, pre-certification, prior approval, fraud detection, auditing and extensive reporting detailing utilization are provided for by the State Employees Health Plan and through its contract with its claims processing contractor, Blue Cross/ Blue Shield of North Carolina.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☒ Geographic area served by the Plan: **entire state of North Carolina**

4.1.2. ☒ Age: **Six to the 19th birthday**

4.1.3. ☒ Income

- **At or below 200% of the federal poverty level (FPL)**
- **Methodologies for determining family income will be the same as for Title XIX**
- **Allow deduction for child care and standard work expense consistent with Title XIX poverty level group.**
- **A family must present pay stubs of all working household members for one month prior to enrollment. A small business owner must present business income proofs acceptable to the Medicaid program**
- **Family size is determined by counting all children in the home in the needs unit of the children applying for SCHIP, including those children receiving Medicaid.**

4.1.4. Resources (including any standards relating to spend downs and disposition of resources

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): **Resident of North Carolina**

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☒ Access to or coverage under other health coverage: **Uninsured means the applicant is, and was not covered under, any private or employer-sponsored creditable health insurance plan on the date of enrollment into the program, and is ineligible for Medicaid, Medicare or other federal government sponsored insurance. The child must be in a family that meets the following family income requirements: at or below 200% of the federal poverty level and above current NC Title XIX levels (6-18—100%). This will be**

determined by the county Social Services case worker after all other eligibility criteria have been established. Enrollment in the plan will begin on the first day of the month following a verified date for end of coverage. Cases that qualify due to dropping private insurance will be electronically coded so the state may determine if the crowd out rate is impacted.

4.1.8 ☒ Duration of eligibility: **12 months**

4.1.9. ☒ Other standards (identify and describe):

- **Eligible under federal law**
- **Ineligible for coverage under Title XIX**
- **Not an inmate in a public institution**
- **If income over 150% FPL, have paid the enrollment fee (with the exception for members of federally recognized Native American tribes.)**
- **Each recipient child shall provide a social security number. A non-recipient parent is not required to submit his own social security number in order for his children to be considered.**

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

Enrollment process:

Families may apply using mail-in applications that can be found at local health departments, and county DSS offices, and on special displays at a variety of locations including but not limited to grocery stores, pharmacies, and discount stores. Applications can also be found at the human resources (personnel) offices of major employers, through all federally funded programs, targeted outreach to public schools and day

care centers (by calling the toll-free hotline published extensively by Title V and DMA), and in person at specially designated outstations. In addition, families may obtain applications at specified medical providers, including Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), migrant health centers, and Indian health centers. Certain State agencies with frequent public contact such as drivers license and vehicle tag sites also have mail-in application forms available.

Enrollment form:

A self-completed, simplified mail-in application form is used for families with children for both Title XIX and Title XXI. Forms are available in Spanish. These forms were developed through focus groups and tested for ease of readability. Assistance in filling out the forms is available through county DSS offices and at specially designated outstations (see above). Information and a mail-in application form are available and posted on the NC Health Choice site on the internet (http://www.dhhs.state.nc.us/dma/cpcont.htm).

Enrollment fee:

Before a child can be enrolled, a family enrollment fee of $50 for one child or $100 for two or more children shall be paid to the County DSS for those families whose income falls between 150% and 200% of the federal poverty level. Upon presentation of proof of membership in a federally recognized Native American tribe, this requirement shall be waived. These funds are kept by the county to help offset its administrative costs.

Eligibility Determination:

- **NC Health Choice provides 12 months continuous eligibility without regard to changes in income.**
- **County DSS determines eligibility for both Title XIX and Title XXI.**
- **County DSS evaluates whether there is Title XIX eligibility, obtain income verifications, and request any additional information if necessary. If income is within Title XIX limits, the child will be enrolled in Medicaid. If over the Medicaid income limit but within 200% of FPL, the child will be enrolled in Health Choice.**
- **Applications are processed within the standard for Title XIX applications (i.e. 45 days from the date of application.)**
- **Counties will collect an enrollment fee when family income is at or above 150% of the federal poverty level unless the family when**

declaring race has presented evidence (such as a Tribal Membership Card) that they are members of a federally recognized Native American tribe. If this has occurred, no enrollment fee is owed.

- **Because North Carolina State Employee dependents receive no subsidy from government sources and parents must pay full premium costs, children of state employees and teachers have been determined to be eligible for coverage under Title XXI.**

Enrollment Method:

- **County DSS enters enrollment information into statewide Eligibility Information System (EIS)**
- **The EIS sends eligibility updates nightly to the State Employees Health Plan.**
- **EIS generates a notice of denial or approval for benefits for the applicant.**
- **The State Employees Health Plan sends out health identification cards, benefits booklets (in English and Spanish), and other related program information.**

Continuing Enrollment:

- **NC Health Choice provides 12 months continuous eligibility without regard to changes in income.**
- **Local agencies receive a "kit" of materials to assist in publicizing ongoing enrollment efforts.**
- **During the eleventh month following enrollment, individuals are sent: (1) a post card asking them to expect a reenrollment form, and (2) a copy of the mail-in application form with a cover letter reminding them that it is time to apply to continue enrollment.**
- **Re-enrollment requirements are the same as initial enrollment. For continued enrollment, the family is sent a form with address information completed on it. Forms may be self-completed/edited, signed and mailed into county DSS.**
- **The local agency has administrative flexibility to use mail-in requests for information, telephone follow-up, and face-to-face interviews.**

The experience of the typical enrollee will be as follows:

The family, upon hearing about this opportunity and then receiving written material at their child's day care (or other source), fills out the application form and mails it to the county DSS office. The local DSS worker assesses the form and makes one of three possible determinations:

1. **The child is eligible for Title XIX. This information is data entered and the child is enrolled in Medicaid.**

2. **The child is eligible for Title XXI. This information is data entered and sent to the Division of Medical Assistance, whereupon one of two things happens: (a) the child is enrolled in the Title XXI program upon receipt of an enrollment fee for families above 150% of poverty ($50 enrollment fee for one child and $100 fee for two or more children paid to the county Department of Social Services) and their information is forwarded to the State Employees Health Plan for inclusion in the program, or (b) it is determined that the funds have been depleted and the child is denied and placed on a waiting list.**

   If the child is found eligible for either Title XIX or XXI and is enrolled, the family will receive by mail a card for the child and written instructions. In the case of Title XXI participants, the cover letter and card will be generated by State Employees Health Plan to welcome them to the program. The letter will inform the parent(s) how to access their children's providers and will include information on copays, out of pocket limits, etc. For children enrolled in the Title XXI program, during the eleventh month of eligibility the family will automatically receive a mail-in application form with a cover letter reminding the family that it is time for plan renewal.

3. **The child is ineligible for both Title XIX and Title XXI either due to income and/or insurance coverage. In the event of an enrollment freeze an enrolled child whose family submits a valid application for reenrollment prior to the end of the ten-day grace period will be reenrolled in the program.**

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☐ Check here if this section does not apply to your state.

Effective January 1, 2006, the enrollment growth of Title XXI, Health Choice, is limited to three percent every six months. In the event that enrollments in the program exceed the three percent cap or the available budget, The Secretary may halt new enrollments until such time as enrollment levels are administratively deemed to be budgeted within the legislated parameters. Notifications will be provided to the US DHHS CMS 45 days in advance of the implementation of any enrollment cap. Public notification will be announced to the current enrollees by letter 30 days prior to the imposition of an enrollment cap and to the news media no later than 20 days before a new enrollment cap is to be implemented. The purpose of the plan is to limit enrollment in a manner that does not impose an extra burden on families to file multiple applications and it allows children to enroll as slots become available rather than waiting for a pre-established date. The initial closure will last a minimum of two months to allow the first full set of re-enrollments to have grace period and to build a safety buffer of open slots.

Enrollments shall be permitted as follows:

Families will continue to file applications and counties will determine eligibility as usual. If a child is determined eligible for Medicaid, then the application is approved and the child is issued benefits. If the child is determined ineligible for any program, the application is denied. If the child qualifies for NC Health Choice, the application will be denied and the family will be notified that the child qualifies for the program but that no funds are available for the program. The state's Eligibility Information System (EIS) will establish a computerized waiting list and add the child to the waiting list. Information about the child will not be transmitted to the claims processing agent until such time as the program enrollment is reopened.

Should the family be an existing NCHC family and re-enroll during the 10-day grace period, the children will continue to have coverage.

Reactivation of applications from the waiting list.

When the NCDMA determines that it is financially possible to allow for new enrollees, it will notify the Division of Information Resources Management (DIRM) of the number of slots that can be filled. US DHHS CMS will be notified on the same day that DIRM receives its notification.

At the point of application, a registration number will be filed so that the applications can be sequenced chronologically according to the date originally registered in EIS. The applications will be reactivated on a first-come, first-serve basis according to this chronological order. When a child's application is reactivated, he or she is removed from the waiting list. The family is mailed notification that its application has been re-opened. The notification letter asks that the family confirm its address and uninsurance status and to return it to the state. This permits the state to act on the family's behalf and reactivate the application. A maximum of 45 days processing time will be allowed for the application to be considered and for the family to provide any needed information.

If the family does not return the reactivation notice the county checks agency records to see if an address change has occurred and will mail a second notice. The county DSS acts on the returned notice to complete the application. The DSS notifies the family if there is any enrollment fee due and the family is asked to pay it. The family is officially notified of the outcome of the reopened application and the child(ren)'s record is transmitted to the claims processing agent. Benefits begin the month the application was "re-activated" and will continue for 12 consecutive months (e.g. the month of 're-activations' is month 1 of the 12 months).

Should a family not reply within 45 days, the "re-activated" application is denied: the number of slots represented by the children in the family become available. The children do not return to the waiting list. The family can reapply at any time.

In the event that the budget shortfall or growth cap is eliminated, the backlogged wait-listed children must be enrolled in the program before the process returns to one with no waiting list.

If a case on the waiting list is re-activated within 3 months, then families will reaffirm their insurance status. The State will use the income that was verified when applicant first applied to determine eligibility when re-activated. If a case is on the waiting list longer than 3 months, then the insurance and income will be reaffirmed at re-activation.

All families will receive a reactivation letter that will ask them to respond to the county DSS within 10 calendar days. If the initial letter is returned to the county DSS because it couldn't be delivered, the county will follow established procedures to determine a current address. Once a current

address is found, the letter will be mailed to the family. The family will be given 10 calendar days to respond. The 45-day processing period will begin the day the case is reactivated. We will be electronically opening an application. The two, ten day periods will fall within that 45 days.

Children will be taken off the waiting list on a first come-first serve basis, regardless of medical condition or income level.

CMS will be notified before any freeze is put into place or any waiting list is initiated. There will also be public notice to the families and through the media before such time as a waiting list is to be imposed.

Regarding children who are required to pay enrollment fees in order to reenroll, the enrollment fee is part of the enrollment process. Failure to pay the enrollment fee is tantamount to not completing the enrollment process. Should the enrollment fee not be paid for reenrollment, the child would be denied reenrollment and would have to go onto the waiting list. Children who have applied and found eligible for the program and are placed on the waiting list for any reason, do not have to pay the enrollment fee until they are permitted to go off the waiting list and enroll in the program. At that point in time, if their family income so dictates, they must pay the enrollment fee to enroll in the program.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))**

Income limits for eligibility for Title XXI are higher than those for Title XIX for children ages six through 18. Screening determines eligibility under the appropriate program. During the application process, the existing Title XIX Eligibility Information System (EIS) are queried to ascertain if the child has Medicaid coverage. The application is first processed for Title XIX eligibility; Title XXI will be pursued only if the child is ineligible for regular Title XIX services, and only for children without existing health care coverage. Income will be assessed at application and at annual redetermination of eligibility. All eligibility in Medicaid and Title XXI is continuous for 12 months without regard to income.

Computerized edits in the Eligibility Information System will prevent enrollment in Title XXI if income is within Title XIX threshold levels. Because state employees and teachers in North Carolina pay full price for their health insurance with no governmental subsidy of any kind, employees of the State of North Carolina are eligible for the program.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

The State uses the same mechanisms and entities in the eligibility determination process for Title XIX and Title XXI. Eligible children are enrolled in the appropriate program as determined by eligibility criteria. One worker processes an application (same application for both Title XIX and XXI). After other criteria are met, the worker assesses family income and determines if the child is eligible for Title XIX or Title XXI or ineligible for either.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

The State uses the same mechanisms and entities in the eligibility determination process for Title XIX and Title XXI. Eligible children are enrolled in the appropriate program as determined by eligibility criteria. One worker processes an application (same application for both Title XIX and XXI). After other criteria are met, the worker assesses family income and determines if the child is eligible for Title XIX, Title XXI or ineligible for either. If a Medicaid eligible family (or children) reports increased income that makes them ineligible for Medicaid, the children are automatically assessed for SCHIP eligibility.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The applicant must not be covered under any private

or employer-sponsored, creditable health insurance plan on the date of enrollment into the program, and is ineligible for Medicaid, Medicare or other federal government sponsored insurance. Cases that qualify due to dropping private insurance will be electronically coded so the state may determine if the "crowd out" rate is impacted. Each case is processed through a system to match the family to the primary insurance providers in North Carolina. It is the same system used for Medicaid. In addition, the claims processor runs periodic screens to double check the child's insurance coverage. If creditable insurance coverage is found, the claim is denied and the case is referred to the Division of Medical Assistance, Program Integrity Fraud Unit.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

All children in the state who are eligible for assistance will be targeted through outreach efforts specifically outlined in Section 5. Organizations that provide outreach to the Native American population will also be targeted. Representation from the Commission on Indian Affairs and the Eastern Band of the Cherokee serve on the Outreach Committee and assisted in the

crafting of both the overall Outreach Strategy and the specific strategy to best reach the State's Native American community. Native Americans who are members of a federally recognized tribe do not have any out of pocket cost under the program. NC Health Choice has worked closely with the Eastern Band of the Cherokee to assure that all families with potentially eligible children have been reached and told of this program and the benefits it offers to the child and the tribe.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

North Carolina employs a simple, seamless marketing approach for both the Title XIX and XXI Programs. Marketing approaches use social marketing research and consider the needs of diverse populations (e.g., bilingual, TTY, etc.) The Division of Public Health has added a position focusing specifically on outreach for Medicaid and Health Choice for minority populations including African American, Native American, Hispanic/Latino and Hmong. Outreach/promotion and marketing are coordinated at the State level through existing public/private partnerships. The Outreach Coalition meets jointly with the RWJ Covering Kids and Families to each strengthen the efforts of the other. The Outreach Coalition is co-chaired by the North Carolina Pediatric Society Foundation and alternates between the Division of Medical Assistance and the Division of Public Health. The Coalition includes the Office of Rural Health and Resource Development, the Commission on Indian Affairs, the Departments of Public Instruction, the NC Partnership for Children, the NC Covenant for Children and the NC Health Access Coalition among others. The state works collaboratively with First Step outreach efforts (a State effort to reduce infant mortality), has a hotline to provide information, referral and advocacy services to the parents of children who may be eligible for Title XIX or XXI Programs. Has a separate hotline to deal specifically with families of children with Special Health Care needs. There are activities at the community and state level to engage organizations, health care providers and consumers in outreach and enrollment efforts. In fact, a Providers Task Force comprised of health care providers (Major Medical Centers, the NC Hospital Association, the Pediatric Society, the NC Academy of Family Physicians, the NC Dental Society, the NC Opticians Society, the NC Association of Independent Pharmacists and others) has supplemented the state's outreach effort and engaged the providers of the state in outreach activity as well as participation in the program. The state also works with counties to assist them in locally-based outreach/promotion & marketing, enrollment and utilization, and tracking activities. The State marketing efforts assist local designees with enrollment drive activities.

Eligibility Determination/Enrollment

The outreach strategy has two goals. The first goal is to increase general awareness of the increased access the program offers to families in North Carolina; second, to assist in educating families about how to best use the health care system to improve the wellbeing of their children.

The overall outreach strategy provides a number of program benefits:

> **(1) to assure that children who are eligible for Title XIX are enrolled in Title XIX;**
> **(2) to prevent children from being inadvertently enrolled in two programs;**
> **(3) to provide one consistent source of enrollment data, and**
> **(4) to avoid a substantive investment to create a new computerized information system for Title XXI.**

The State has implemented Federal options to simplify the Title XIX and XXI enrollment process including annual re-determination, a simplified application, decentralized enrollment through out-stationed staff (enrollment "drives") and the development of a mail-in application. In addition, the State explored and engaged as many others as possible in the outreach and enrollment process (e.g. public/private providers, schools, Smart Start, day care, work sites, etc.) Title XXI and Title XIX now have continuous eligibility for 12 months without regard to changes in income.

Implementation

In each county outreach is conducted through collaborative implementation efforts between the local Departments of Health and Social Services with guidance from the State Outreach Coalition.

General public awareness campaigns have been conducted through the NC Healthy Start Foundation (a 501 C-3 organization) with statewide media campaigns conducted through the Public Information Office of NCDHHS. The name of the program was selected through focus groups conducted statewide. County-based publicity kits were developed by the National Covering Kids Campaign and by the Healthy Start Foundation.

Local Department of Social Services employees identify potentially eligible families and facilitate the completion of applications. These efforts include working with child care providers and public schools to

solicit their help in identifying eligible families and assisting them with the application process. In addition, the assistance of the NC Council of Churches has been sought to encourage all places of worship to inform their congregations of the importance of the availability of children's health insurance, Titles XIX and XXI and to assist in the application process. The assistance of the NC Pediatric Society and the NC Academy of Family Physicians was enlisted to provide their patients with information on Titles XIX/XXI. Providers have also been urged to remind patients to reenroll when their 12-month eligibility period was about to expire.

Using a simplified mail-in application form, applicants first are screened for Title XIX eligibility, then for Title XXI. If they are found to be ineligible for both programs, applicants are provided with information on Title V clinics for preventive health services at the local health department. They are encouraged to consider purchasing health insurance for their children. The process was developed in such a way that trips to local social services agencies are not necessary. Mail in applications, out-stationed sites and telephone interviews are used. Because eligibility is one year only, renewal applications are mailed at 11 months with a cover letter explaining where to turn for assistance if help is needed in completing the renewal application.

<u>Targeted Population Outreach</u>

The Division of Public Health has added a position focusing specifically on outreach for Medicaid and Health Choice for minority populations including African American, Native American, Hispanic/Latino and Hmong. North Carolina's minority populations have been successfully targeted through a combined approach using minority media, religious organizations, social and cultural organizations. The broad outlines for minority outreach efforts, developed by representatives of the respective racial or ethnic groups are as follows:

The African American population is targeted through:

- **11 newspapers in the state identified by the NC Black Publishers Association as those with an editorial focus targeting black readers.**
- **Urban, Gospel and Jazz radio stations as listed through Arbitron Media Research as African American**
- **Predominantly African American religious organizations through such projects as Black Churches United for Better**

Health.

- **Such social and service organizations as the NAACP and service sororities and fraternities**

Native Americans in North Carolina are targeted through:

- **The North Carolina Commission on Indian Affairs**
- **Pow-wows held statewide**
- **Tribal newsletters and two newspapers which target Native American readers.**
- **Tribal organizations**
- **Native American Youth and Cultural Groups**
- **Community Action Agencies**
- **Rural and Migrant Health Centers**

Hispanic Communities are reached through:

- **Four Hispanic newspapers**
- **Spanish language television and radio stations**
- **Community Action Agencies**
- **Rural and Migrant Health Centers**
- **Community grocery stores**

Homeless families in North Carolina are targeted through:

- **Rescue Missions**
- **Church Shelters**
- **Health Departments**
- **Local Social Services Departments**
- **Community Action Agencies**
- **Rural and Migrant Health Centers**

Information and a (U.S.) mail-in application form are posted on the Internet.

A Medical Home

As NC Health Choice population began to exhaust the dollars available through state funds, it became clear that it was time to assist NC Health Choice members' parents to better understand how to best use the health care system and how to keep their children healthy. With this, targeted efforts to promote wellness and disease management strategies were implemented. A claims

analysis revealed that the leading causes of emergency department visits were for otitis media, fever and upper respiratory infections. Materials have been developed in both English and Spanish helping parents to know what to do, when to see their child's doctor and when to go to the emergency room. Additional materials have been developed to encourage families to choose a provider to become their child's medical home so that they will always have someone who knows their child to turn to for help as well information on how to prepare for a doctor's visit so that it will work for the child.

Efforts have also been undertaken to identify children with asthma and to assure that they are receiving all the help they need to prevent emergency episodes. One of the major foci of the program right now is medical management: identification of frequent or high cost episodes and outreaching health information to those families.

5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

The strategies for outreach/promotion and marketing, and eligibility determination/enrollment are identical for both the Title XIX and XXI programs as outlined in 5.1. The Division of Medical Assistance administers the program in concert with the local Departments of Social Services for determination of eligibility. Children are determined eligible or ineligible for Title XIX using the same application form as for Title XXI.

Children who are not eligible for Title XIX are evaluated for Title XXI eligibility and automatically enrolled if income criteria are met. Outstationed eligibility staff, including those placed at Federally Qualified Health Centers and Disproportionate Share Hospitals, accepts applications for both Title XIX and XXI programs through a common process.

Applications are made available on self-service displays in easy access locations.

An enrollee in the Program who loses eligibility due to an increase in family income above 200% FPL and up to and including 225% FPL may purchase at full premium cost, continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The same benefits, co-payments, and other conditions of enrollment shall

apply to extended coverage.

No State or federal funds are used to cover, subsidize or otherwise offset the cost of this extended coverage.

The Department coordinates efforts with the State Health Plan to assure that children with "special needs" receive the same level of services that are available under Title XIX in North Carolina, including case management services to enhance outcomes and control costs. A special fund, comprised of Title XXI federal funds and state matching funds will be established to reimburse the services that are above and beyond those covered by the State Health Plan. This component will be administered by the State Title V Children's Special Health Services Program in the Department. "Children with Special Needs" are those who have been diagnosed as having one or more of the following conditions which in the opinion of the diagnosing physician (1) is likely to continue indefinitely, (2) interferes with daily routine, and (3) requires extensive medical intervention and extensive family management:

a. **Birth defect, including genetic, congenital or acquired disorders;**
b. **Developmental disabilities; or**
c. **Chronic and complex illness**

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section**

2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan
6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
6.1.4.4. ☒ Coverage that includes benchmark coverage plus additional coverage
Base plan is benchmarked in the State Employees Health Plan plus dental, vision and hearing coverage and special needs coverage to the Medicaid level.
6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage
6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Please provide a sample of how the comparison will be done)
6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**

Room and board (semi-private accommodations, unless the hospital has only private rooms); medically necessary supplies; medication; laboratory tests; radiological services; operating/recovery rooms; and hospital staff. Hospital admissions must be pre-certified. The State Health Plan requires a second surgical opinion for coronary artery bypass; hysterectomy; knee surgery; revision of nasal structure; unless the procedure is performed on an emergency basis.

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**

The State Employees Health Plan provides benefits for covered diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital outpatient setting or in an ambulatory surgical facility; preadmission diagnostic tests before hospital admission within 14 days of a scheduled hospital admission.

6.2.3. ☒ Physician services **(Section 2110(a)(3))**

Eligible medical providers are Doctor of Medicine; Doctor of Osteopathy; Doctor of Podiatry; Doctor of Chiropractic; office visits for preventive services such as unlimited well-baby visits up to one year of age; 1 visit per year between 2 and 7; once every three years between seven and 19 years of age. Immunizations are covered.

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

Standard surgical procedures; related services; surgeon's fees, including preoperative and some post-operative visits; anesthesia. Assistant surgeons are covered when medical judgment requires surgical assistance and no hospital-employed physician in training is available. When two or more surgical procedures are covered at the same time if there are separate incisions, the surgeon will be paid at the rate of the higher usual and customary charge and 50% of

the charge of the second procedure. If the same incision is used, the surgeon will be paid for the one surgical procedure that has the higher UCR allowance. Prior approvals are needed for abdominoplasty, blepharoplasty, cochlear implants, excision of gynecomastia, fimbrioplasty, gastric surgery for morbid obesity, hermaphroditism, keloid excision, nasal structure revision, oral surgery (developmental and congenital orthognathic surgeries, necessitated as a direct result of medical treatment), penile prosthesis, reduction mammoplasty, subcutaneous injection, suction lipectomy, temporomandibular joint (TMJ) dysfunction appliance therapy (limited to injury), transplants, tubotubal anastomsis.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

The State Employees Health Plan provides benefits for covered diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital outpatient setting or in an ambulatory surgical facility; 1 visit per year between 2 and 7; once every three years between seven and 19 years of age. Immunizations are covered.

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**

6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. ☒ Pre-natal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**

Prenatal care and childbirth are not covered. Counseling and advice about contraception and prescription drugs for contraception are covered.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))** **(Section 2110(a)(10))**

Pre-certification must be obtained from the Mental Health

Case Manager (in order to be eligible, patient must be confined to a licensed mental health bed and treated by an eligible mental health provider) for the following: residential treatment in a psychiatric setting, urgent admissions, chemical dependency, psychological testing (except when included in the hospital's or treatment program's daily charge, hypnotherapy, sodium amytal interviews, electroconvulsive treatment; stress, relaxation and occupational therapies (except when included in the hospital's or treatment program's daily charge); psychosurgery.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

More than 26 outpatient visits per plan year (combined with outpatient substance abuse visits) require precertification from the Mental Health Case Manager (patient responsible for keeping track of the number of visits); psychological testing over and above that performed during the 26 visits will also require pre-certification from the Mental Health Case Manager.

6.2.12. ☒ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

Must be standard equipment that is normally used in an institutional setting, able to withstand repeated use, primarily and customarily used to serve a medical purpose, generally not useful in the absence of an illness or injury, appropriate for use in the home (such as a standard hospital bed, standard wheelchair, nebulizer, etc.) and not used for the convenience of the caregiver, reasonable and medically necessary for the treatment of a specific illness or injury.

VISION: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every

24 months, and optical supplies and solutions when needed. Optical services, supplies and solutions must be obtained from licensed or certified opthamologists, optometrists, or optical dispensing laboratories. Eyeglass lenses are limited to single vision, bifocal, trifocal, or other complex lenses necessary for an enrollee's visual welfare. Coverage for oversized lenses, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses, and laminated lenses is limited to the coverage of single vision, bifocal, trifocal or other complex lenses. Eyeglass frames are limited to those made of zylonite, metal or a combination of zylonite and metal. All visual aids require prior approval of the State Health Plan. Upon prior approval by the State Health Plan refractions may be covered more often than once every 12 months.
HEARING: Auditory diagnostic testing services and hearing aids and accessories when provided by a licensed or certified audiologist, otolaryngologist, or other hearing aid specialist approved by the State Health Plan. Prior approval of the State Health Plan is required for hearing aids, accessories, earmolds, repairs, loaners, and rental aids.

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13)) therapeutic only**

6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

The State Employees Health Plan limits home and community-based services to patients who are homebound, need for therapy that can only be performed by licensed health care professionals, physician -certified that the patient would otherwise be confined to a hospital or skilled nursing facility without home care services, must have rehabilitation potential. Require prior approval and include private nursing duty, home care aides (under the direct supervision of a registered nurse and employed by a licensed home care agency), skilled nursing visits, hospice care, therapy (speech, physical and occupational, and home intravenous (IV) therapy. Intensive in-home behavioral health services are covered under the Core Benefit portion of the plan as a specialized intensive outpatient program. These services include crisis management, parent

reeducation or family systems therapy. Not covered are care provided by a family member, care provided by a non-skilled or unlicensed care giver, such as a sitter, when the patient's condition no longer requires a skilled level of care, when the maximum rehabilitation potential has been met.

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

Abortion is not covered.

6.2.17. ☒ Dental services **(Section 2110(a)(17))**

Oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth X rays once every 60 months, supplemental bitewing X rays showing the back of the teeth once during a 12-month period, fluoride applications twice during a 12-month period, sealants, simple extractions, therapeutic pulpotomies, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth colored filling material to restore diseased teeth.

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18)**)

Pre-certification must be obtained from the Mental Health Case Manager (in order to be eligible, patient must be confined to a licensed substance abuse bed and treated by an eligible substance abuse provider) for the following: residential treatment in a psychiatric setting, urgent admissions, chemical dependency, psychological testing (except when included in the hospital's or treatment program's daily charge); hypnotherapy; sodium amytal interviews; electroconvulsive treatment; psychosurgery. Detoxification may be obtained on a licensed medical unit, psychiatric unit, or substance abuse unit if pre-certified by the mental health case manager.

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

More than 26 outpatient visits per plan year (combined with

the outpatient mental health visits) require pre-certification from the Mental Health Case Manager (patient responsible for keeping track of the number of visits); psychological testing over and above that performed during the 26 visits will also require certification from the Mental Health Case Manager.

6.2.20. ☒ Case management services **(Section 2110(a)(20))**

6.2.21. ☒ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

The Department will coordinate efforts with the State Health Plan to assure that "children with 'special needs'" receive the same level of services that are available under Title XIX in North Carolina. Service requests for children with special needs are reviewed by one or more of the following: Division of Public Health specialty clinicians, contracted vendor for mental/behavioral health (including behavioral health group homes) and/or nurses/physicians at claims processing contractor. Funds and service utilization for CSHCN, above the core services are regularly tracked and analyzed to improve proactive program and budget planning. The State Title V program for Children with Special Health Care Needs has lead responsibility for coordinating services and benefits for children who are medically high cost and for children meeting the following definition:

"Children with Special Needs" are those who have been diagnosed as having one or more of the following conditions which in the opinion of the diagnosing physician (1) is likely to continue indefinitely, (2) interferes with daily routine, and (3) requires extensive medical intervention and extensive family management:

a. Birth defect, including genetic, congenital or acquire disorders;
b. Developmental disabilities; or
c. Chronic and complex illness.

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

Ambulance transportation is covered including air ambulance under certain emergency situations

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (**2102(a)(7)(A)) (42CFR 457.495(a))**

The Department will perform satisfaction surveys. A random sample of all participating families will be asked to complete a survey periodically. Questions on the survey will be determined by input received from families, providers, and experts/researchers in the field. Sample measures are:

- **Proportion of parents that rate the care provided to the child is poor, appropriate, good, or excellent**
- **Proportion of parents reporting that they are satisfied with their role in making decisions about their child's care**
- **Proportion of parents reporting satisfaction with the availability and choice of primary and specialty providers.**
- **Proportion of parents reporting satisfaction with the amount of time providers spend with the child**
- **Proportion of parents who filed formal complaints or grievances.**
- **Average waiting time for appointments for preventive; primary, or specialty care.**
- **Travel time and distance to receive preventive, primary and specialty care.**

The use of prevention services will be evaluated through the following measures.

Well-child screening rate, by age (AAP standards)

- **ages 6-11**
- **ages 12-18**

The rate of use of acute care services will be measured by the following measures:

- **Number and rate of ambulatory visits per 1000 member months, by age**

- **Number and rate of emergency room visits per 1000 member months**
- **Number and rate of hospital stays per 1000 member months, by age**
- **Average length of hospital stay**

The adequacy of services for special needs children will be measured with advice from the NC Commission on Children with Special Health Care Needs. Attention will be focused on children with high cost and/or high incidence conditions such as:

- **Asthma**
- **Diabetes**
- **Emotional Behavioral Conditions**

Measures for these children may include:

- **Proportion of children who have hospital stays, and length of stay**
- **Percent of children requesting/receiving durable medical equipment**
- **Types and number of mental health/behavioral health services received by age of child**
- **Information from periodic surveys where questions target CSHCN**
- **Use of emergency room by CSHCN**

Notable gaps in service act as trigger points for consultation with the Commission for Special Health Care Needs to evaluate the service and develop a recommendation to improve care for the consideration by the Secretary of DHHS and the NC General Assembly.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards
7.1.2. ☒ Performance measurement -- **HEDIS measures will be used**
7.1.3. ☒ Information strategies – **parent surveys and claims data will be used**
7.1.4. ☒ Quality improvement strategies --

The Provider Task Force has agreed to include as part of its mission, acting as the Quality Assurance/Improvement group to review compliance with quality standards as revised. This team represents state agencies, provider groups, insurers and others associated with

health care delivery.

7.2. Describe the methods used, including monitoring, to assure: (**2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

Review of paid claims data, in-house focused studies, independent studies by researchers, parent surveys, comparison with state immunization registry.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

Review of paid claims data. Department of Insurance laws on access with prudent layperson standards on emergency care. Recent studies have shown that the most frequent reasons for emergency room visits are ear infection, fever, and upper respiratory infection. Materials have been developed to assist families in caring for their children with these conditions and to know when the situation warrants an Emergency Room visit and which does not. Other focused studies on asthma have led to dramatic decreases in ER visits for asthma patients.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

NC Health Choice is an any-willing-provider indemnity plan. Therefore, there are no network providers. There is an internal review of every denied claim to assess whether or not it meets Medicaid criteria. If it does, it is paid according to Medicaid criteria. Families and providers may also appeal any denial of service. DMA, DPH and the State Health Plan periodically conduct focused studies on high cost or high incidence conditions and develop strategic preventive or early intervention protocols. Should a problem exist, an education campaign targeted to providers is conducted.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Decisions on prior authorization are made in accordance with the medical needs of the patient 14 days after receipt of a request for services. These are verified through spot checking and provider feedback, parent surveys, and reports from the Claims Processing Contractor.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES
8.1.2. ☐ NO**, skip to question 8.8.**

8.2. Describe the amount of cost sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. **(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))**

For all members of federally recognized Native American tribes there is no cost sharing.

For families below 150% of the federal poverty level (FPL), there is cost sharing for prescription drugs only.

For families above 150% FPL, there is an annual enrollment fee of $50 for one child or $100 for two or more children ($100 annual maximum) plus copays.

8.2.1. Premiums:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments

Copayments:

Families below 150% will pay copayments as follows:

- **For prescription drugs: $1 for generic, $1 for brand with no generic available, $3 for generic with a brand available**

Families above 150% will pay copayments as follows:

- **For prescription drugs: $1 for generic, $1 for brand with no generic available $10 for generic with a brand available;**
- **$5 for each physician visit, dental and optometry visit except for preventive services,**

- **$5 for outpatient hospital visits, and**
- **$20 co-payment for unnecessary emergency room use.**

Families who have been exempted from cost-sharing as members of federally recognized Native American Tribes will not be subject to copayments and a $0 copayment will be printed on their health insurance card.

8.2.4. Other:

Enrollment fees are required only of those families above 150% of the federal poverty level. These fees, $50 for one child, $100 for two or more children, are used to offset the cost of administration by county Departments of Social Services. These funds are retained by the counties for this use. In a similar fashion, providers keep any copayments paid to them.

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

These charges are prominently posted on the website for the program, in all literature produced for the program, on the application form and on membership cards. Any changes are made through an act of the NC General Assembly which both publicly debates proposed changes and receives media coverage for the changes it makes. Once a change is made, letters are sent to all members in accordance with North Carolina Medicaid's ten day notification rule. This rule requires that a letter be sent in order for the recipient to know about the change ten days before it goes into effect.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☒ Cost sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

The type and amount of co-payment is set at levels that are extremely unlikely to exceed the upper limit. The Division of Medical Assistance, through EIS, will notify the State Employees Health Plan of the limit to the amount of co-pay. The State Employees Health Plan will electronically accumulate the money spent on cost sharing by each individual and notify the family via a letter when the dollar amount is met. The notification can be shown to providers who will then forgive any further co-payment. As a precaution, a report will be generated annually that lists income levels for individuals for whom co-payment amount exceeds 5% of 100% of annual federal poverty guidelines for an individual. This assures that the lowest possible annual income for a Title XXI eligible is the threshold. During federal fiscal years 2002- 03 and 2003-04 period, no families have exceeded the five percent threshold.

In the cases of families who are at or below 150% of federal poverty level, the medication management claims processing system receives computer based case file numbers, when the family reaches the $14 per month limit, the automatic eligibility system will notify pharmacists that no copay is required. In case of error caused by filing delays, a manual review of the data will be run on the fifth of every month and families will be reimbursed should computer notification fail to work.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

Counties will collect enrollment fee when family income is at or above 150% FPL unless the family when declaring race has presented evidence (such as a Tribal Membership Card) that they are members of a federally recognized Native American tribe. If this has occurred, no enrollment fee is owed. When eligibility is determined and the membership card issued, the figure $0 will be printed on the copayments lines for those families who presented a tribal membership card upon enrollment. In addition, a letter has been sent to the federally recognized Native American Tribal Councils of North Carolina, asking for their assistance in making sure that their tribal members identify themselves at enrollment as members of a federally recognized Native American tribe.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

The family whose income is above 150% and does not present a tribal identity card and is, therefore, subject to an enrollment fee and that does not pay an enrollment fee is not enrolled until the fee is paid. A family required to pay a copayment that does not pay remains enrolled in the program. An individual provider may at his or her discretion refuse service over non-payment of a copayment. Enrollment fees are the property of the county in which the application is filed. Copayments are the property of the provider. A family can reenroll at any time during the first ten days of the month and have it count as a reenrollment. This becomes a significant benefit during a time of an enrollment freeze when reenrollees are allowed to stay in the program if they reenroll on a timely basis.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

The State of North Carolina does not disenroll anyone under the current system unless the family actively requests a change of DSS status that makes them Medicaid eligible or if the family notifies the state that they have purchased health insurance. If the State makes changes in the program that would permit disenrollment we would make sure that:

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**

☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching

requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration
(Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

- **To reduce the number of uninsured children living in families with incomes below 200% of the federal poverty guidelines.**
- **To encourage utilization of preventive health care services.**
- **To increase child health screenings among enrolled children**

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

- **Maintain the enrollment in the program within fundable limits**
- **Measured customer satisfaction and reported program utilization will remain at the 90% or better rate.**
- **Analysis of paid claims data at least twice annually to assure well child checkups at appropriate levels**

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

Using Title XIX's Medically Indigent Children program measure the increases of children enrolled by parents seeking health insurance only since the inception of the SCHIP program.

9.3.2. ☒ The reduction in the percentage of uninsured children.

Using CPS estimates divide the total numbers of children covered under NC Health Choice and Medicaid by the numbers of uninsured to establish the rate of decrease per year.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

In lieu of a managed care program, NC Health Choice is undertaking an outreach campaign to encourage families to voluntarily select a primary care practitioner. Computer runs of most frequently used providers will help to trigger the initial thrust of the campaign.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

Outcomes measures will be assessed by the Provider Task Force and the Division of Public Health to determine progress on identified health problems

9.3.5 ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.(HEDIS-like measures developed for indemnity programs).

NC Health Choice will use the four HEDIS style measures adopted by CMS.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
9.3.7.1 ☒ Immunizations
9.3.7.2. ☒ Well-child care
9.3.7.3. ☒ Adolescent well visits
9.3.7.4. ☒ Satisfaction with care
9.3.7.5. ☐ Mental health
9.3.7.6. ☐ Dental care
9.3.7.7 ☒ Other, please list:

- **Asthma measures**
- **Well child screenings**

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

Upon receipt of the Annual Plan Template the NCHC Coordinator sends appropriate template sections to various agencies and requests that information be provided. Usually a meeting is held with all applicable parties to go through an overview of the questions in the report, to explain the importance of compliance with the requests and to set deadlines. In addition a list of quality measures is presented to the Information Technology sections of both the Division of Medical Assistance and Blue Cross Blue Shield to ask that claims analyses be run. Usually a separate meeting with the information technology workers is necessary to clarify exactly which HEDIS data is being requested. The Coordinator gathers all the information and using it, writes the report, sometimes simply cutting and pasting, in other cases substantially rewriting submissions. In many cases, the Coordinator knows some of the information from personal involvement or research and writes it up in total. Through the year, when it is deemed necessary to gather additional data, the Coordinator assesses whether or not the resources exist in state government to run analyses (in which case, requests are submitted to applicable agencies), or if other groups need to be involved. In every case, the Annual Report is submitted for review and edits to all parties and agencies involved in the provision of services for NC Health Choice. Once these edits have been made, and the Report approved by the Division Director, the report is submitted.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

- 9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

A Task Force was appointed by the Secretary of the North Carolina Department of Health and Human Services to develop recommendations for implementation of the Title XXI Children's Health Plan. Membership of the Task Force included state government officials, local government officials, health care providers from the private sector, recipient advocates, insurance company representatives, Health Maintenance Organization representatives, and various other interested parties. The Task Force worked closely with local advisory groups comprised of representation from county level departments of Social Services, local health departments, area Mental Health agencies (now referred to as Local Management Entities), etc. A copy of the Task Force report can be found at http://www.dhhs.state.nc.us/dma/CHIP/task.htm. In addition, some 10 public meetings were held across the state before the General Assembly met to consider the Title XXI plan. The General Assembly met for six weeks in special session to consider only the Title XXI plan. The session was the subject of intense public scrutiny and input.

The General Assembly established the Governor's Commission on Children with Special Health Care Needs to assure that the needs of this population are being met. The entire Title XXI program is also subject to monitoring by the Joint Legislative Health Care Oversight Committee.

In addition, an Outreach Advisory Panel was appointed with the ongoing responsibility of assuring public involvement in the program. The Outreach Advisory Panel (as described in Section 5) is designed to maximize public involvement from provider groups, local programs, and an inclusive cadre of racial and ethnic groups. Subsets of each racial and ethnic group have

been established to design outreach to their respective racial and ethnic groups.

A Providers Task Force also exists to seek advice and counsel of the entire provider community. Members include representatives of the NC Pediatric Society, the NC Hospital Association, the NC Dental Society, the NC Family Practitioners Association, the opticians, hearing specialists, academic medical centers, academic dental centers, etc. The Task Force is consulted on program changes, for assistance with outreach and other advice and counsel.

In 2002-2003, the NC General Assembly requested a status report on NC Health Choice. They requested that the NC Institute of Medicine (IOM) review the program and make recommendations for any changes in the program. Several months of study yielded a list of recommendations which were presented to the General Assembly in their 2003-2004 session. One recommendation that was adopted was to change pharmacy prescription rates to encourage the use of generic medications. Another recommendation from this report that was adopted was to move the 0-5 year olds to Medicaid in order to access EPSDT services and assure continual coverage from birth through age 5.

All changes to the NC Title XXI Plan are required by state law to go through the legislative process and to be subject to the public scrutiny of any law change except for those changes the Secretary of DHHS may make to special needs. Should such a change be planned for children with special health care needs, the change would first be brought before the Governor's Commission for Special Health Care Needs for that body's advice and consent. These meeting are public meetings. Before the change could be implemented letters would have to be mailed to family members 30 days in advance of the change and public notice would need to be published in at least one newspaper in the state.

When major change is considered in the program, the Secretary of NC DHHS, the Governor and the NC General Assembly have asked the NC Institute of Medicine (IOM) or other independent body to convene an appropriate mix of members of the legislative, provider groups and advocacy groups to assure that the best alternatives are recommended to the legislative body. All IOM meetings are public meetings.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **(Section**

2107(c)) (42CFR 457.120(c))

Federally recognized Native American tribes are actively consulted by phone, email, letters and/or visits to discuss questions and procedures regarding outreach, benefits, billing, eligibility and enrollment and cost sharing. In addition, efforts are made to keep non-federally recognized tribes informed and involved through the NC Commission on Indian Affairs, inclusion of representatives from non-federally recognized tribes on statewide outreach groups and through representation of the program by state employees at Pow Wows held by various tribes across the state.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

All changes to the NC Title XXI Plan (see note on previous page regarding special needs) are required by state law to go through the legislative process and to be subject to the public scrutiny of any law change. Therefore, proposed changes are published in news articles, on television, on radio and in newsletters of various associations and advocacy groups. In addition, when major change is considered in the program, the Secretary of NC DHHS, the Governor and the NC General Assembly have asked the NC Institute of Medicine to call together an appropriate mix of members of the legislature, provider groups and advocacy groups to assure that the best alternatives are recommended to the legislative body. All IOM meetings are public meetings.

In addition, when major change is considered in the program, the Secretary of NC DHHS, the Governor and the NC General Assembly have asked the NC Institute of Medicine to convene an appropriate mix of members of the legislature, provider groups and advocacy groups to assure that the best alterations are recommended to the legislative body. All IOM meetings are public meetings.

For example, in the recent case of a change in cost sharing for prescription drugs, the concept was first raised in fall of 2002 in a meeting of the NC Health Choice Task Force of the NC Institute of Medicine, There were a series of public meetings called at the request of the NC General Assembly and the Secretary of NC Health and Human Services to decide how to best reform NC

Health Choice in light of budget shortfalls. The calling of the NC Institute of Medicine to examine these issues was well publicized in the mass media. The deliberations of the NC IOM Task Force were publicized as were its findings and recommendations. Legislation evolved from these recommendations. Several bills were submitted to the NC General Assembly by their membership. Among the recommendations was a call to attempt to modify behavior among NCHC families by charging nominal amounts for generic drugs and greater amounts for brand drugs. This recommendation passed. Included on the Task Force were representatives of the major advocacy groups for children in the state. Once the legislation passed as part of the budget process of the NC General Assembly 2003 session (July, 2003), letters were sent to members informing them that this change would take place on February 1, 2004. The time was needed to reprogram computers so that we could assure that federally recognized Native Americans would not be charged any out-of-pocket costs. The state worked closely with the Eastern Band of the Cherokee and the Catawba to ensure that these citizens would not be charged out of pocket costs.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

Benefits	**Reporting Period FY 2005**	**Next Fiscal Year 2006**
Insurance payments	**$275,812,039**	**$291,477,782**
Managed Care		
Per member/Per month rate @ # of eligibles	**$168.85**	$196.74
Fee for Service		
Total Benefit Costs		
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs	**$275,812,039**	**$291,477,782**
Administrative Costs		
Personnel	**$51,695**	$69,427
General Administration	**$6,629,724**	$1,424,251
Contractors/Brokers (e.g., enrollment contractors)		
Claims Processing		
Outreach/Marketing costs	**$550,935**	$936,594
Other		
Total Administration Costs	**$7,232,354**	**$2,430,272**
10% Administrative Cap (net benefit costs ÷ 9)	**$30,645,782**	**$32,386,420**
Federal Title XXI Share	**$210,981,291**	**$218,785,155**
State Share	**$72,063,102**	**$75,122,899**
TOTAL COSTS OF APPROVED SCHIP PLAN	**$283,044,393**	**$293,908,054**

co-payments and enrollment feeds do not generate "offsetting costs." Enrollment fees are kept by the counties to partially compensate them for eligibility determination. No county participation is required in the NC Health Choice benefits payment. Co-payments are kept by providers who are then paid at a reduced rate by the claims payer. (For example, physicians keep co-pays paid to them, pharmacists keep co-payments made to them and hospitals keep co-pays paid to them.) During federal fiscal year 2004, a total of $2,079,317.79 was collected by counties in enrollment fees. Providers collected $234,194.31 in co-payments from those at or below 150% FPL (beginning February 2004) and $2,067,374.27 from those from 151% to 200% FPL.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

Eligibility and Enrollment use the same services and systems as those used by the Title XIX program. Recipients receive their notices and options both verbally and in writing; expedited reviews are available at each step.

Health Services Matters

12.2 Please describe the review process for **health services matters** that comply with 42 CFR 457.1120.

Health services matters use the same services and systems as those used by the State Health Plan as follows:

Two levels of internal review are available for Medical, Pharmacy, and Mental Health disputes. The first level review is by the Claims Processing Contractor. A written report is sent to the member, and if that review is not satisfactory to the member, the second is by a team coordinated by the CPC with medical specialty providers by phone.

The third level review can be made at the choice of the complainant to the Department of Insurance, the State Plan Administrator and Board or an outside medical consultant.

Each level generally requires written response within a maximum of 60 days, however, expedited reviews are available. These substantially shorten the time taken for a decision.

If the individual complainant still has unresolved issues after the process, the member may take the matter up with the Managed Care Patient Assistant Program in the NC Department of Justice. NC law specifically includes both the State Employees Health Plan and the NC Health Choice program included under this jurisdiction.

Recipients receive their notices and options both verbally and in writing; expedited reviews are available at each step.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.