North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

April 30, 2013

The Honorable Louis Pate, Chair
Appropriations on Health and
Human Services
Room 1028, Legislative Building
Raleigh, North Carolina 27601-2808

The Honorable Ralph Hise, Chair
Appropriations on Health and
Human Services
Room 1026, Legislative Office Building
Raleigh, North Carolina 27601-2808

Dear Senators Pate and Hise:

In accordance with G.S. 108A-70.27(b), the Department of Health and Human Services submits an annual report on the North Carolina Health Choice (NCHC) program to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Appropriations Subcommittee on Health and Human Services.

North Carolina's Title XXI Children's Health Insurance Program (CHIP), the Health Choice Program for Children, provides health care coverage for children of working families who earn too much to qualify for the Title XIX Medical Assistance Program (the State Medicaid Program) and too little to afford private or employer-sponsored health insurance. This report provides the program's vital statistics for fiscal year 2012 and illustrates relevant trends in cost and utilization.

Please direct all questions concerning this report to Sarah Pfau, Health Choice Program Acting Chief, in the Division of Medical Assistance at 919-855-4137.

Sincerely,

Aldona Wos, M.D.
Secretary

Attachment

cc: Susan Jacobs
Pam Kilpatrick
Patricia Porter
Sarah Riser
Kristi Huff
Brandon Greife
Jim Slate
Adam Sholar
Carol Steckel
Legislative Library (one hard copy)
Reports@ncleg.net

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April 30, 2013

The Honorable Marilyn Avila, Chair
Appropriations Subcommittee on Health
and Human Services
Room 2217, Legislative Building
Raleigh, North Carolina 27601-1096

The Honorable William Brisson, Chair
Appropriations Subcommittee on Health
and Human Services
Room 405, Legislative Office Building
Raleigh, North Carolina 27603-5925

The Honorable Mark Hollo, Chair
Appropriations Subcommittee on Health
and Human Services
Room 639, Legislative Office Building
Raleigh, North Carolina 27603-5925

Dear Representatives Avila, Brisson, and Hollo:

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Telephone 919-855-4800 • Fax 919-715-4645
Location: 101 Blair Drive • Adams Building • Raleigh, NC 27603
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Ambassador (Ret.)
Secretary DHHS

April 30, 2013

The Honorable Justin Burr, Chair
Joint Legislative Oversight Committee
on Health and Human Services
Room 307A, Legislative Office Building
Raleigh, North Carolina 27603-5925

The Honorable Nelson Dollar, Chair
Joint Legislative Oversight Committee
on Health and Human Services
Room 307B1, Legislative Office Building
Raleigh, North Carolina 27603-5925

The Honorable Louis Pate, Chair
Joint Legislative Oversight Committee
on Health and Human Services
Room 1028, Legislative Building
Raleigh, North Carolina 27601-2808

Dear Representatives Burr and Dollar and Senator Pate:

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Secretary DHHS

April 30, 2013

Mark Trogdon, Director
Fiscal Research Division
N.C. General Assembly
300 N. Salisbury Street
Suite 619, Legislative Office Building
Raleigh, N.C. 27603

Dear Mr. Trogdon:

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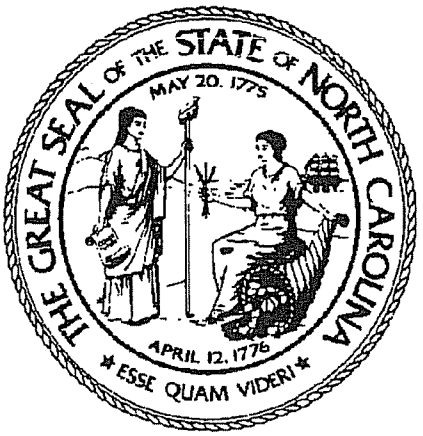
NC Health Choice for Children

Annual Report to the North Carolina General Assembly

State Fiscal Year 2012



State of North Carolina

Department of Health and Human Services

Division of Medical Assistance

INTRODUCTION

In accordance with G.S. 108A-70.27(b), the Department of Health and Human Services submits the following annual report on the North Carolina Health Choice program to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Appropriations Subcommittee on Health and Human Services.

North Carolina's Title XXI Children's Health Insurance Program (CHIP), the Health Choice Program for Children (Health Choice), provides comprehensive health care coverage for children of working families who earn too much to qualify for the Title XIX Medical Assistance Program (the State Medicaid Program) and too little to afford private or employer-sponsored health insurance.

The statute requires the Department to collect and analyze the following data for the Health Choice program:

1. Number of applicants for coverage;
2. Number of applicants deemed eligible for Medicaid;
3. Number of applicants deemed eligible, by income level, age, and family size;
4. Number of applicants deemed ineligible and the basis for ineligibility;
5. Number of applications made at county departments of social services, public health departments, and by mail;
6. Total number of children enrolled to date and for the immediately preceding fiscal year;
7. Total number of children enrolled in Medicaid through the Health Choice application process;
8. Trends showing the Health Choice program's impact on hospital utilization, immunization rates, and other indicators of quality of care, and cost-effectiveness and efficiency;
9. Trends relating to the health status of children; and
10. Other relevant data.

Additionally, the statute requires a report on:

- Health Choice areas working most and least effectively;
- Performance measures used to ensure quality, fiscal integrity, ease of access, and appropriate utilization of preventive and medical care;
- Efficacy of system linkages in addressing access, quality of care, and efficiency; and
- Recommended changes to improve efficiency and effectiveness.

PROGRAM OVERVIEW

Title XXI Children's Health Insurance Program

Title XXI of the federal Social Security Act authorizes federal funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children through the Children's Health Insurance Program (CHIP) authorized at 42 U.S.C. 1397a *et seq.* Enhanced Federal Medical Assistance Percentage (eFMAP) funding is provided for CHIP and adjusted annually; it accounted for approximately 75 percent of North Carolina's Title XXI health insurance coverage funding in SFY 2012. State appropriations and other non-appropriated funds provided the remaining 25 percent. Unlike Medicaid, CHIP is not an entitlement program and State funding is capped. The General Assembly is not obligated to appropriate funds for the program.

The North Carolina General Assembly established the North Carolina Health Choice for Children Program in 1998 under G.S. §108A-70.20.. North Carolina has a combination plan consisting of a separate Child Health Insurance Program (Health Choice) for children ages 6 through 18, and a Medicaid Expansion Program for children from birth through 5 years of age. Children in the Medicaid Expansion program receive the same benefit plan as older children enrolled in the Medicaid Title XIX program, but North Carolina receives the Title XXI eFMAP for the cost to insure them.

Health Choice serves children who:

- are uninsured and ages 6 through 18 years (up to the last day of the month in which the beneficiary turns 19);
- live in a family with income between 101 percent and 200 percent of the Federal Poverty Level (FPL), which is updated annually;
- are ineligible for Medicaid, Medicare, or other federal government sponsored health insurance;
- are residents of North Carolina and eligible under Federal law; and
- have paid the Program enrollment fee.

The Medicaid Expansion program serves children who:

- are ages 0 (newborn) through 12 months with a family income between 186 percent and 200 percent of FPL; and
- are ages 13 months through 5 years with a family income between 134 percent and 200 percent of FPL.

In addition to Health Choice and the Medicaid Expansion Program, there is a State-funded, Extended Coverage option authorized by G.S. 108A-70.21(g). At the time of the annual renewal review for continued eligibility, children residing in families with income exceeding Health Choice eligibility requirements may be eligible to purchase up to 12 consecutive months of *transitional* health insurance immediately following the last month of Health Choice or Medicaid Expansion eligibility. As of January 2013, the monthly premium per child is $201.61.

Extended Coverage is available to children who:

- Have immediate prior enrollment in Health Choice;
- Reside in a family with income between 201 and 225 percent of the FPL; and
- Have been canceled from Health Choice at renewal because of excess family income.

All other Health Choice eligibility requirements apply.

Uninsured Children in North Carolina

The U.S. Census Bureau's Current Population Survey 2012 Annual Social and Economic Supplement estimated the number of children in North Carolina under 18 years of age living below 200 percent of the FPL to be 1,108,000 or 47.9 percent of that population. More than 850,000 or 36.8 percent of North Carolina children under 18 years of age were estimated to be living below 150 percent of the FPL. More than 550,000 or 24.1 percent of North Carolina children under 18 years of age were estimated to be living below 100 percent of the FPL.

In North Carolina, children living at or below 100 percent of the Federal Poverty Level may be eligible for Medicaid coverage, and children living at 101 to 200 percent of the Federal Poverty Level may be eligible for Health Choice coverage. **Table 1** illustrates the number of Health Choice beneficiaries by percent of the Federal Poverty Level and household size in SFY 2012.

Table 1: Health Choice Beneficiaries by Federal Poverty Level and Household Size: SFY 2012

Family Size	101 – 150% FPL	151 - 200% FPL
1	4,594	17,417
2	7,017	24,168
3	4,984	10,372
4	1,480	2,723
5	512	289
6	113	54
7	21	14
8	24	48
9	0	0
10	0	0
11	0	11

Source: Client Services Data Warehouse. Household income is based on countable monthly income.

In November 2012, the North Carolina Institute of Medicine (NCIOM) released its annual Child Health Report Card. The Report Card described the availability of and access to health care and preventive health services for North Carolina children. It revealed that between 2006 and 2011, the percentage of uninsured children ages 0 through 18 in North Carolina decreased by nearly 31 percent. The Report Card documented a simultaneous 26.5 percent increase in public health insurance coverage for children ages 0 – 18 from 2006 to 2011, with 864,664 children enrolled in either Medicaid or Health Choice in 2006 and 1,093,504 children enrolled in one of the Programs in 2011. These North Carolina statistics reflect the success of the Health Choice program's goal of reducing the number of uninsured, low-income children in the State since the

program's inception. The Report Card also revealed a disparity in the percentage of uninsured children within the overall state population (9.4%) and the percentage of uninsured children among North Carolina families living below 200 percent of the Federal Poverty Level (12.8%). North Carolina disparities mirror national statistics: the U.S. Census Bureau 2011 estimate of the percentage of uninsured children under the age of 19 was 9.7 percent among all children and 13.8 percent among children living in poverty (*Source: U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2011).*

PROGRAM ELIGIBILITY

Applicants may enroll in person or by mail using a joint application for the Medicaid and Health Choice programs. County Department of Social Services (DSS) caseworkers facilitate on-site completion either face-to-face or via telephone. Health Choice eligibility is determined by the DSS in the county in which the applicant resides. Health Choice applicants are evaluated for the following criteria as set forth in G.S. § 108A-70.21(a):

- Age 6 through 18;
- Family income from 101 percent to 200 percent of the federal poverty income level;
- Ineligible for Medicaid, Medicare, or other federal government sponsored health insurance;
- Uninsured [not covered under any private or employer-sponsored comprehensive health insurance plan on the date of enrollment per G.S. § 108A-70.18(8)];
- Resident of North Carolina and eligible under federal law; and
- Paid the enrollment fee (when applicable).

If family income is within Title XIX program limits and an applicant meets all other Medicaid eligibility requirements, DSS will enroll the applicant in Medicaid. If family income exceeds the Medicaid income limit, is at or below 200 percent of the federal poverty income level, and all other Title XXI program eligibility requirements are met, DSS will enroll the applicant in Health Choice as long as any applicable enrollment fee or premium has been paid. In accordance with G.S. 108A-70.21(c), the annual enrollment fee for beneficiaries living at 151-200 percent of the FPL is fifty dollars ($50.00) per 12 month continuous enrollment period per child, with a maximum fee of one hundred dollars ($100.00) for two or more children.

Applicant Demographics

Table 3 shows the distribution of eligible applicants by family size and percent of the Federal Poverty Level. The income levels are not arbitrary; G.S. 108A-70.21(c) and (d) establish these for the purpose of assigning cost sharing obligations to Health Choice beneficiaries.

Income Level

The Federal Poverty Level (FPL) is adjusted every year in April. The income limits in **Table 2** were effective in January of 2012.

Table 2.

2012 Federal HHS Poverty Guidelines (*annual income*)			
Persons in Family	**48 Contiguous States and D.C.**	**Alaska**	**Hawaii**
1	$12,860	$13,970	$12,860
2	17,410	18,920	17,410
3	21,960	23,870	21,960
4	26,510	28,820	26,510
5	31,060	33,770	31,060
6	35,610	38,720	35,610
7	40,160	43,670	40,160
8	44,710	48,620	44,710

Source: Federal Register, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035.

To qualify for the Health Choice Program, a family's income cannot exceed 200 percent of the FPL. In SFY 2012, 75 percent of NC Health Choice applicants had family incomes between 151 percent and 200 percent of the FPL, and 25 percent of the applicants had family incomes at or below 150 percent of the FPL.

Table 3: Eligible Applicants Ages 6 – 18 by Family Size and Income Level: SFY 2012

Family Size	101 – 150% FPL	151-200% FPL
1	5,228	19,127
2	7,120	24,334
3	5,001	10,407
4	1,484	2,728
5	290	515
6	54	114
7	14	21
8	24	24
9	0	0
10	0	0
11	11	0
TOTAL	**19,226**	**57,270**

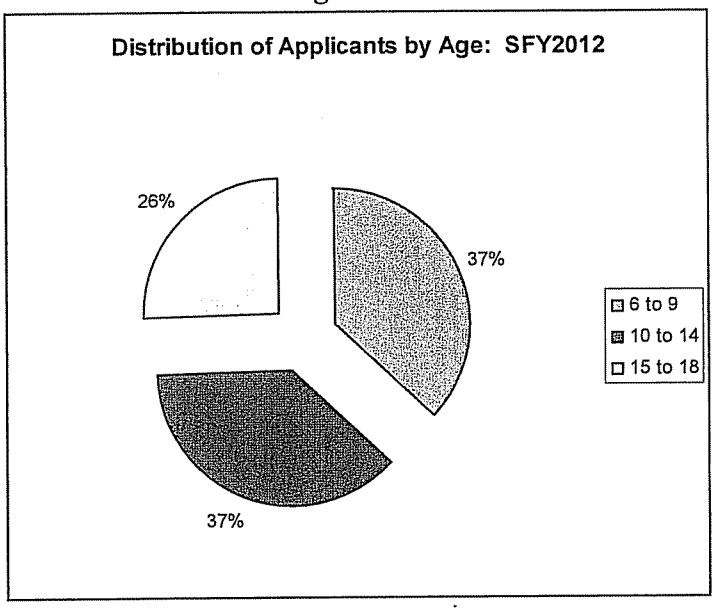
Additional notes with respect to income level include the following:

- Health Choice beneficiaries living in families with income at or below 150 percent of the FPL are exempt from paying the program enrollment fee.
- Additional cost sharing distinctions between beneficiaries living at or below 150 percent of the FPL and beneficiaries living at 151- 200 percent of the FPL are presented in **Table 4** on page 15.
- The Division of Medical Assistance is authorized to impose cost sharing in federal Title XXI regulations and G.S. 108A-70.21(d).

Age

Figure 1 shows the distribution of Health Choice applicants by age in years.

Figure 1.



Application Denials

A total of 1,443 Health Choice applications were denied in SFY 2012. G.S. 108A-70.26(c) allows applicants to appeal eligibility determination decisions. Denial of program applications may be based on the program eligibility criteria listed on page 3. The greatest percentage of denials were for coverage under other comprehensive health insurance (59%), followed by a family income exceeding the eligibility criteria (38%), followed by non-payment of the annual enrollment fee (3%).

Figure 2 shows the distribution of *denied* applications by application site, and **Figure 3** shows the distribution of *accepted* Health Choice applications by application site. Although in-person applications are not required, more people apply in person than through the mail. The graphs reveal that mail-in applications yield the greatest percentage of denied applications. There are several possible reasons for this trend. Applicants who mail in their applications may not take advantage of the telephone assistance available at the county DSS. Furthermore, language or literacy barriers may pose a challenge because DSS caseworkers often need to request additional or follow-up information for incomplete mail-in applications.

Figure 2.

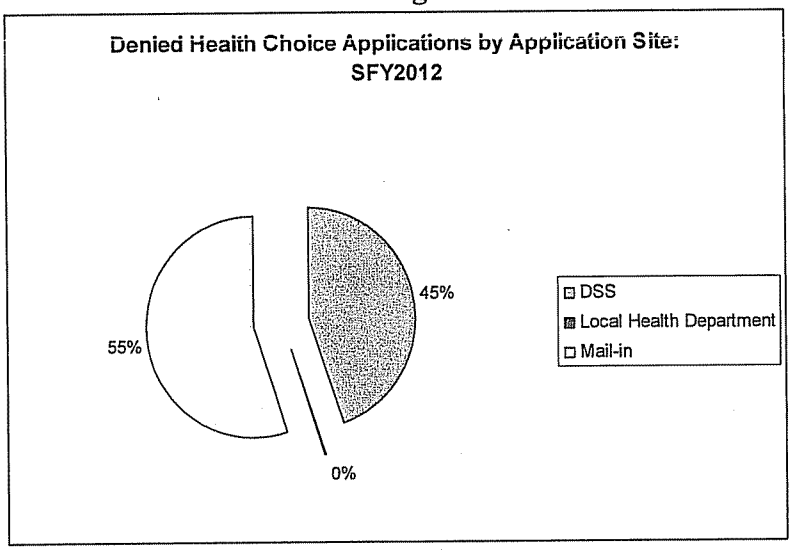
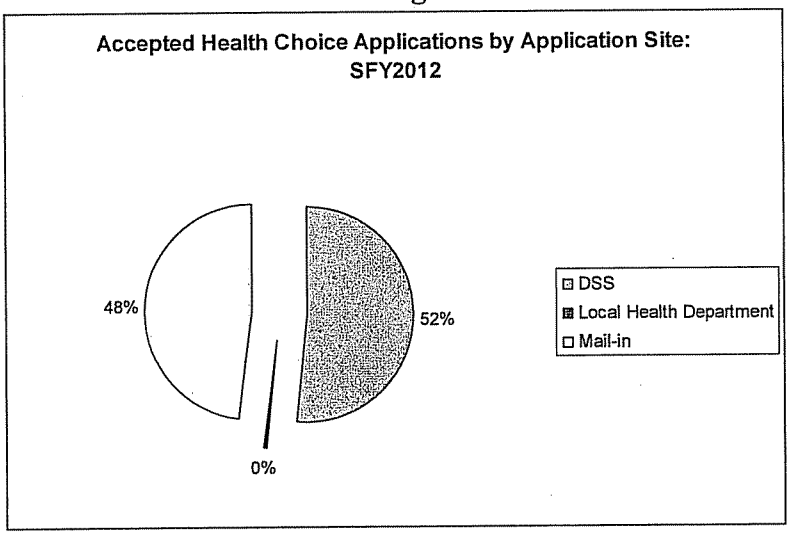


Figure 3.



PROGRAM ENROLLMENT

The Title XXI Children's Health Insurance Program (CHIP) is not an entitlement program like Medicaid. When a State agrees to accept federal funding for the Medicaid program, it agrees to match the Federal Medical Assistance Percentage with as many State dollars as are needed to enroll every eligible applicant. States participating in the CHIP program are entitled to federal child health assistance funding, but they may cap the amount of State funding available to enroll eligible applicants. In the event that there are insufficient State funds, the NC Division of Medical Assistance stops new enrollments following public notice posted a minimum of 30 calendar days prior to the effective date of the enrollment freeze. However, existing Health Choice beneficiaries who undergo a renewal re-evaluation during the freeze period receive a new 12-month period of continuous enrollment if they meet all other eligibility requirements. Throughout the history of the Program, the Division of Medical Assistance has frozen enrollment only once, for six months beginning in January of 2001.

Average monthly enrollment in Health Choice for SFY 2012 was 154,381. **Figure 4** shows the distribution of Health Choice beneficiaries by age in years.

Figure 4.

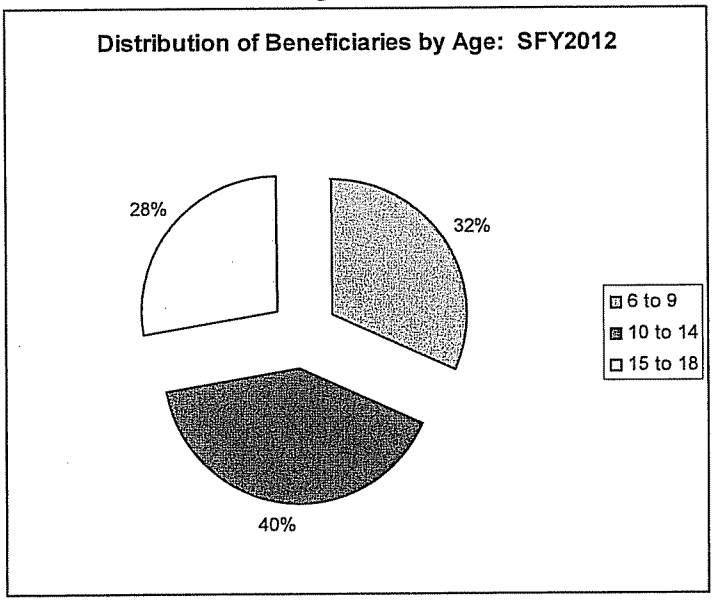


Figure 5 shows the distribution of the 153,601 Health Choice beneficiaries with self-reported race and ethnicity in SFY 2012. In the data category, "AI/AN" represents American Indian or Alaska Native and "PI" represents Hawaii Pacific Islander. **Figure 6** shows the race and ethnicity distribution of the overall North Carolina population compared to the distribution of Health Choice beneficiaries. The graph shows a disproportionate percentage of Black and Hispanic beneficiaries enrolled in Health Choice in relation to their relative representation in the general population. Conversely, the relative proportion of White Health Choice beneficiaries is lower than the representation in the general population.

Figure 5.

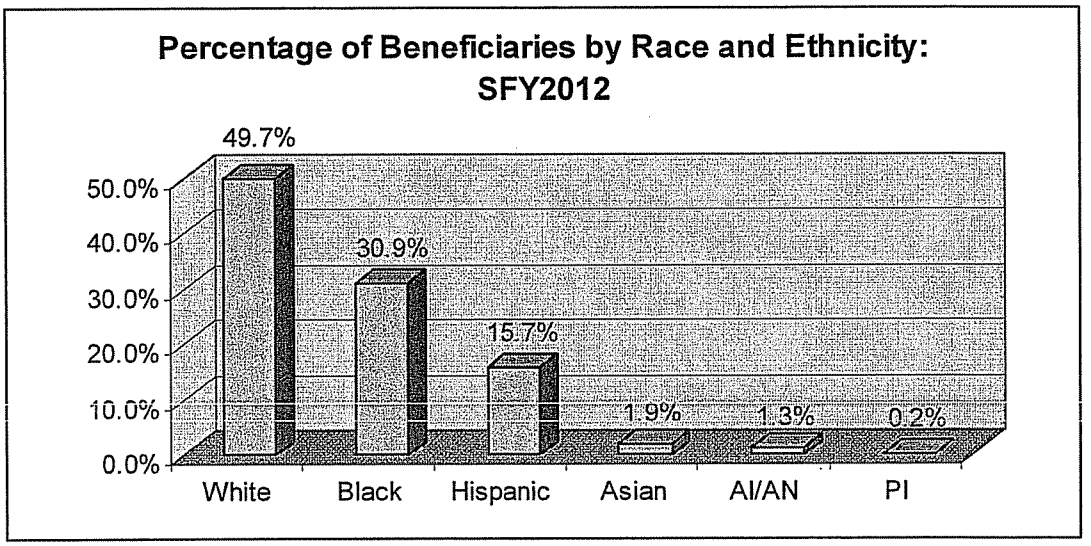
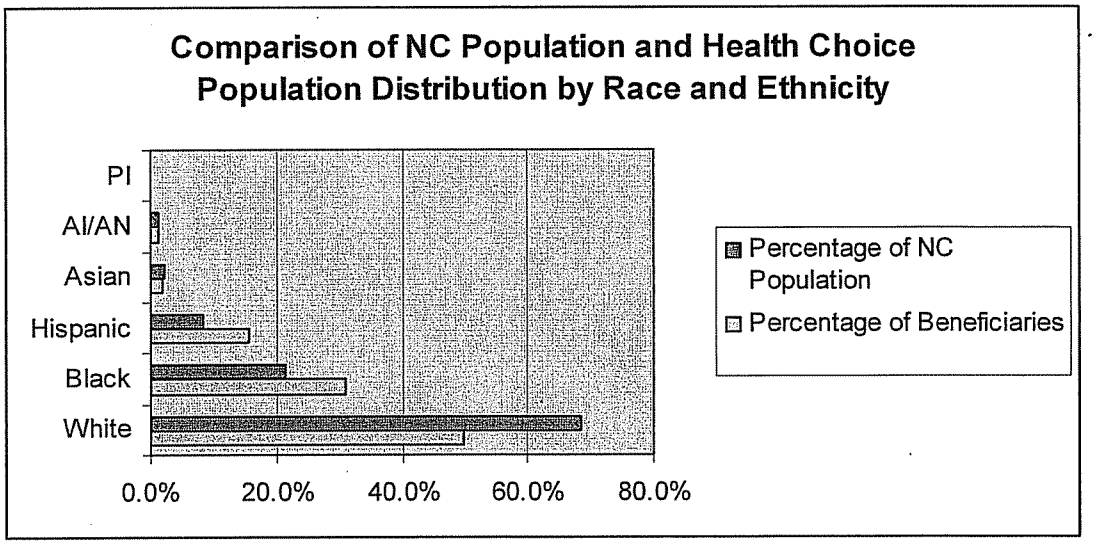


Figure 6



Source: U.S. Census Bureau, 2010 Census Data.

Transition between North Carolina Medicaid and Health Choice Programs

Enrollment in the Health Choice Program is continuous for twelve (12) months, pursuant to G.S. 108A-70.21(4). Although an interim change in a beneficiary's health insurance coverage status may be cause for disenrollment before the end of the twelve months, an increase in household income during the continuous enrollment period will not affect enrollment. Department of Social Services eligibility caseworkers only review household income during the annual renewal review to determine eligibility for a new 12-month enrollment period. However, if family income decreases during the continuous enrollment period, a family may request to apply for Medicaid (with the subsequent disenrollment from Health Choice). Conversely, if a Medicaid beneficiary's household income increases to a point of making him ineligible for the Medicaid program, a family can apply for Health Choice eligibility in a higher income bracket.

In SFY 2012, the number of Health Choice beneficiaries who transitioned to the Medicaid Program was 35,183 (a 2% decrease from SFY 2011) while the number of Medicaid beneficiaries ages 6 through 18 who transitioned to the Health Choice Program was 44,277 (a 3% decrease from SFY 2011). One programmatic challenge posed by this phenomenon that is often referred to as "churn" is continuity of care for beneficiaries. G.S. 108A-70.21(b) requires the following benefits coverage in Health Choice:

> Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
>
> (1) No services for long-term care.
> (2) No nonemergency medical transportation.
> (3) No EPSDT.
> (4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.

EPSDT is Early and Periodic Screening, Diagnosis, and Treatment required by federal statute 42 U.S.C. § 1396d(r) for Medicaid beneficiaries under the age of 21. EPSDT provides coverage for services that are not included in the State Medicaid Plan or Division of Medical Assistance (DMA) medical coverage policies, and prohibits any limits on the number of visits to a provider (for example, for mental health services). Because G.S. 108A-70.21(b)(3) prohibits EPSDT in Health Choice, only services included under the Health Choice State Plan and the DMA medical coverage policies, service definitions, or billing codes are covered for Health Choice beneficiaries. Therefore, the "No EPSDT" exception within Health Choice benefits coverage means that when a beneficiary transitions from Medicaid to Health Choice, he may lose a benefit that he was receiving. However, services covered under the Health Choice State Plan have Medicaid-equivalent coverage in both the Medicaid and Health Choice programs as a result of G.S. 108A-70.21(b). DMA therefore administers combined medical coverage policies for both programs. Those policies are available at: http://www.ncdhhs.gov/dma/mp/index.htm.

PROGRAM OUTREACH

Outreach is a required program component under the federal regulations for Title XXI programs. North Carolina employs a combined marketing approach for the State Title XIX and XXI Programs with joint materials. Outreach approaches employ social marketing principles and consider the needs of diverse populations (e.g., preferred language; ethnic, cultural, and social norms; specific concerns for parents or guardians of children with special health care needs; and materials targeted for low literacy populations).

The Division of Public Health (DPH) leads outreach and marketing efforts through a Memorandum of Agreement with the Division of Medical Assistance and in collaboration with State and local public and private partners. DPH continuously updates the materials and makes them available to partners and the general public. The DPH minority outreach consultant conducts statewide outreach with the primary goals of: 1) building awareness of the State's publicly funded children's health insurance programs; and 2) promoting enrollment and annual re-enrollment of eligible children. The consultant collaborates with community and faith-based organizations to review changes to bilingual outreach materials that are distributed to potential Medicaid Health Check (for individuals under 21 years of age) and Health Choice program applicants. Fact Sheets translated in 12 languages are available for the following Limited English Proficient populations: Arabic, Chinese, French, Hmong, Khmer (Cambodian), Korean, Lao, Portuguese, Rhade (Montagnard), Russian, Spanish, and Vietnamese. The most frequently spoken languages were identified via North Carolina Census and Department of Public Instruction data and discussions with the state's Refugee Resettlement Agencies. Each one-page fact sheet presents the information in English on the back side. The fact sheets highlight income eligibility guidelines, health benefits available, and how to apply. See the link to the online fact sheet on page 31 of this report.

As the Title XXI program has matured since its inception in 1998, North Carolina has re-focused outreach efforts on infrastructure development by working with partners to integrate outreach for child health insurance programs into the ongoing work of their State and local organizations. Many of the partners below meet quarterly as part of the NC Coalition to Promote Children's Health Insurance. State and local partners engaged in child health insurance outreach include:

Early Childhood Organizations: Smart Start (The NC Partnership for Children, Inc.), North Carolina Pre-Kindergarten, Head Start (Early and Migrant populations), and Pre-Kindergarten Programs; Child Care Resource and Referral Agencies; Child Care Health Consultants; NC Association for the Education of Young Children; NC Division of Child Development and Early Education; and various Child Care Provider Associations are all invaluable partners. The preschool age programs in particular educate parents before their children reach the Health Choice eligibility age of six years.

Schools: The NC Department of Public Instruction collaborates through its NC Healthy Schools and Child Nutrition Sections (Free and Reduced Price School Meals). Other related collaborators include the School Nurses Association of North Carolina; School Health Advisory Councils; School Support Services Staff (Psychologists, Social Workers, Counselors); Coaches; School-Based and School Linked Health Centers, and the NC Parent Teacher's Association. The

NC Community Colleges' Basic Skills and Literacy staff have also been partners in assisting with outreach efforts with their GED, Adult High School, and English-as-a-Second-Language classrooms. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) funded a *Healthy and Ready to Learn* initiative. The Governor partnered with the NC Pediatric Society to administer the initiative in North Carolina. With the end of the CHIPRA funding, the initiative was funded with an NC Office of Rural Health grant for SFY 2013 only. To date, 62 Local Education Agencies in 46 of the State's 100 counties have conducted outreach efforts in elementary and middle schools to find and enroll eligible, uninsured children in Health Choice and Health Check (Medicaid).

Health Care Providers: Collaborators include the NC Pediatric Society; the NC Academy of Family Physicians; Local Medical Societies; associations representing Physician Assistants, Nurse Practitioners, and School Nurses; Safety Net Providers (Health Departments; Community, Rural, Indian and Migrant, Health Centers; Free Clinics); the NC Hospital Association; and Hospital Finance and Emergency Department Staff.

Governmental Partners: Several Department of Health and Human Services Divisions (Social Services; Medical Assistance, and Public Health) partner through their respective programs. Other governmental partners include; the Department of Public Instruction; the Employment Security Commission; the Division of Juvenile Justice and Delinquency Prevention; the Housing Authority; Cooperative Extension Agencies; Parks and Recreation Departments; Vocational Rehabilitation agencies; the NC Commission of Indian Affairs; the Refugee Health Program, and the Division of Motor Vehicles. A nine-member Commission is charged with monitoring and evaluating the provision of services to Children with Special Health Care Needs pursuant to G.S. 143-682.

Private Not-for-Profits: These collaborators include Community Action Agencies; Domestic Violence Shelters; United Way / 2-1-1; the Salvation Army; Homeless Shelters; Food Banks; Advocacy Groups; Communities in Schools; Legal Services; Libraries; and Faith-Based, philanthropic, and minority organizations.

Businesses: Collaborators include the NC Association of Health Insurance Underwriters; the NC Hotel / Motel Association; Community College Small Business Centers; Banks; Local Chambers of Commerce, including the NC Hispanic and Black Chambers of Commerce; local ethnic grocery stores and restaurants; and tax preparers—particularly VITA centers across the state.

Media: Radio, television, magazines, press releases, news stories, and local newsletters are employed in Health Choice minority outreach efforts. Ethnic radio stations and Spanish language television stations have worked with the DPH minority outreach consultant. Many of the public service announcements developed under a previous DPH contract with the NC Healthy Start Foundation are still aired by local television stations such as WRAL during weekend children's programming.

Table 4: Health Choice Eligibility Groups and Cost Sharing

Beneficiary Income and Race/Ethnicity Status	Cost-Sharing Responsibility
Family income is 200% or less of FPL and is a member of a federally recognized Native American Tribe or Alaska Native.	• No enrollment fee • No prescription co-payments • No co-payments for office visits

Family income of 101 - 150% of FPL	• No enrollment fee
	  ◦ Generic Prescription co-pay: $1
	  ◦ Brand Prescription when no generic available co-pay: $1
	  ◦ Brand prescription when generic available co-pay: $3
	  ◦ Over-the-counter co-pay: $1
	• No co-payments for office visits
	• $10 non-emergency, emergency room visits

Family income of 151 - 200% of FPL	• Enrollment fee: $50 per child or $100 maximum for two or more.
	  ◦ Generic Prescription co-pay: $1
	  ◦ Brand Prescription when no generic available co-pay: $1
	  ◦ Brand prescription when generic available co-pay: $10
	  ◦ Over-the-counter co-pay: $1
	• $5 co-payments for office visits
	• $25 non-emergency, emergency room visits

Optional extended coverage. Income 200 - 225% FPL
This group pays monthly premiums of $201.61.
	• No enrollment fee
	  ◦ Generic Prescription co-pay: $1
	  ◦ Brand Prescription when no generic available co-pay: $1
	  ◦ Brand prescription when generic available co-pay: $10
	  ◦ Over-the-counter co-pay: $1
	• $5 co-payments for office visits
	• $25 non-emergency, emergency room visits

The co-payment structure in **Table 4** reflects cost sharing amounts in G.S. 108A-70.21(d) as of January 1, 2013. G.S. 108A-70.21(e) restricts the total annual aggregate (12 month, continuous coverage as opposed to a calendar or fiscal year) cost-sharing for beneficiaries subject to co-payments to 5 percent of the family's income. Pursuant to 42 C.F.R. § 457.505(d)(1), all beneficiaries receive well-child visits and age-appropriate immunizations at no cost to their families. For all members of federally recognized Native American tribes and Alaska Natives, there is no cost-sharing imposed. A $0 co-payment is printed on each qualified beneficiary's health insurance card.

OTHER HEALTH CHOICE AND MEDICAID DATA

The following tables illustrate additional trends in the State's public assistance health insurance programs.

Table 5: Total Number of Applications in SFY 2012

Health Choice (Title XXI) (ages 6–18)	Medicaid (Title XIX) (ages 6-18)	Medicaid Expansion (Title XXI) (ages 0–5)	Total
67,257	117,297	12,113	196,667

Table 6: Total Number of Applications since October 1, 1998

Health Choice (Title XXI) (ages 6–18)	Medicaid (Title XIX) (ages 6-18)	Medicaid Expansion (Title XXI) (ages 0–5)	Total
1,107,236	6,696,275	4,372,027	12,175,538

One application is used to determine a child's eligibility for Medicaid and NC Health Choice.

Table 7: Total Number of Children Enrolled in SFY 2012

Health Choice (Title XXI) (ages 6–18)	Medicaid (Title XIX) (ages 6-18)	Medicaid Expansion (Title XXI) (ages 0–5)	Total
200,912	630,049	52,213	883,174

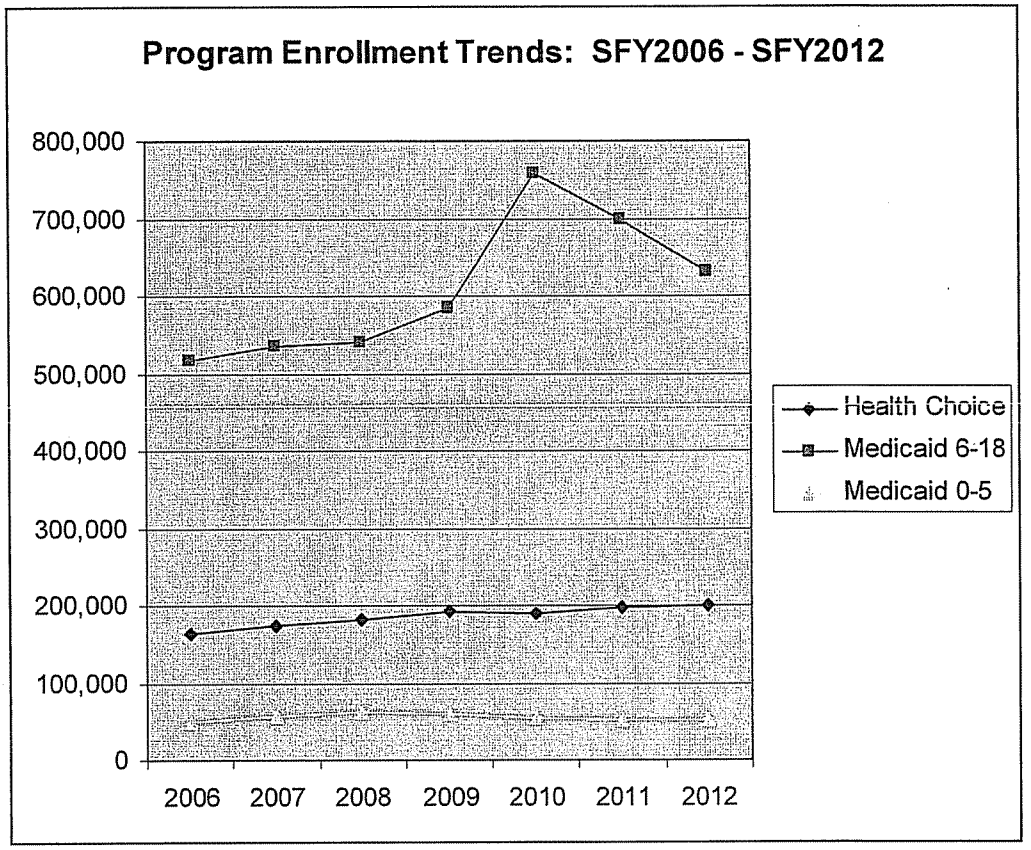
Table 8: Total Number of Children Enrolled to date*

State Fiscal Year	Health Choice (Title XXI) (ages 6–18)	Medicaid (Title XIX) (ages 6–18)	Medicaid Expansion (Title XXI) (ages 0–5)
2006	163,080	517,257	48,334
2007	172,953	535,776	58,293
2008	181,756	540,118	62,128
2009	191,941	585,131	59,975
2010	189,101	759,666	55,653
2011	197,130	699,798	50,919
2012	200,912	630,049	52,213
Total	**1,296,873**	**5,564,668**	**387,515**

**The Client Services Data Warehouse houses retrospective data for only a limited number of years.*

From SFY 2006 to SFY 2012, Health Choice enrollment increased by nearly 20 percent. Medicaid enrollment for children ages 6 through 18 also increased by nearly 20 percent over the span of seven years. Health Choice enrollment decreased only one year during that time, from 2009 to 2010. Between the same two years, the enrollment of 6 through 18 year-olds in Medicaid increased by more than 170,000. The timing of the spike in Medicaid enrollment for children coincided with the national and State recessions. According to the U.S. Bureau of Labor Statistics, the unemployment rates in North Carolina in 2009 and 2010 were 10.2 percent and 10.6 percent, respectively. Medicaid Expansion enrollment for children from birth to age 5 decreased overall by approximately 10,000 beneficiaries from SFY 2008 to SFY 2012. **Figure 7** illustrates these longitudinal enrollment growth trends in the programs.

Figure 7.


Program Enrollment Trends: SFY2006 - SFY2012
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
2006
2007
2008
2009
2010
2011
2012
Health Choice
Medicaid 6-18
Medicaid 0-5

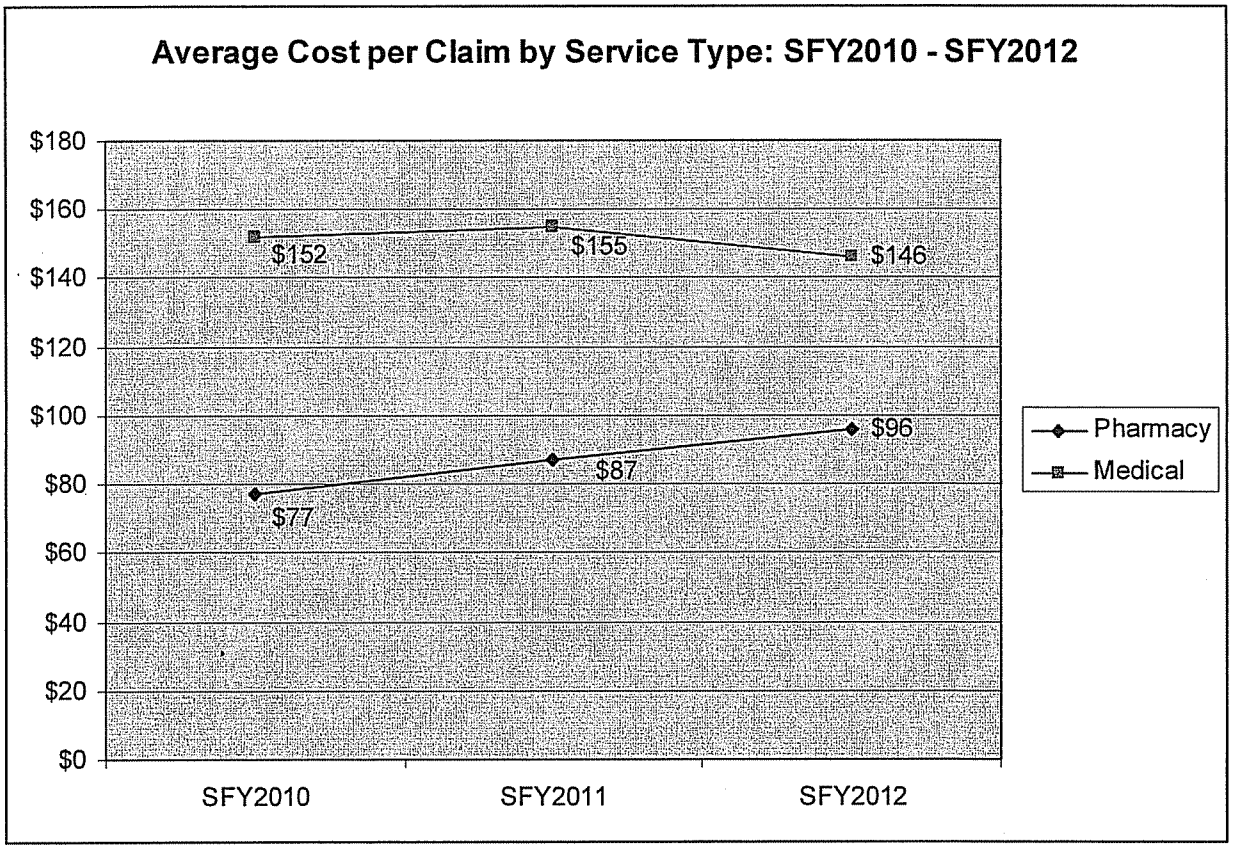
TRENDS IN HEALTH CARE UTILIZATION

Medical and Pharmacy Claims

Figure 8 shows that the average cost per Health Choice beneficiary claim for pharmacy services increased by 20 percent from $77 in SFY 2010 to $96 in SFY 2012. Conversely, the average cost per Health Choice beneficiary *medical* service claim decreased by 4 percent from $152 in SFY 2010 to $146 in SFY 2012.

Utilization review and prior approval requirements for some medical services serve as cost containment measures. The enrollment of every Health Choice beneficiary in a primary care medical home with required referrals for other services may also be keeping the cost of health services utilization down. And finally, with the assignment of a medical home and a consumer education emphasis on preventive (well-child) visits, fewer beneficiaries may be needing treatment services.

Figure 8.



Even though the cost per claim for medical services decreased from SFY 2010 to SFY 2012, the average number of medical service claims per Health Choice beneficiary remained stable over the same time span. And conversely, although the average cost of a pharmacy claim increased, the average number of pharmacy claims per Health Choice beneficiary decreased by 38 percent from SFY 2010 to SFY 2012.

Figure 9 shows the trends in both pharmacy and medical services utilization among Health Choice beneficiaries. It will be important to continue to monitor these trends and assess beneficiaries' health services utilization and outcomes. Although outreach and education about appropriate health services utilization are already components of North Carolina's State Plan Amendment under the Title XXI Children's Health Insurance Program, annual data can help program staff and state-wide collaborators refine their efforts.

Figure 9.

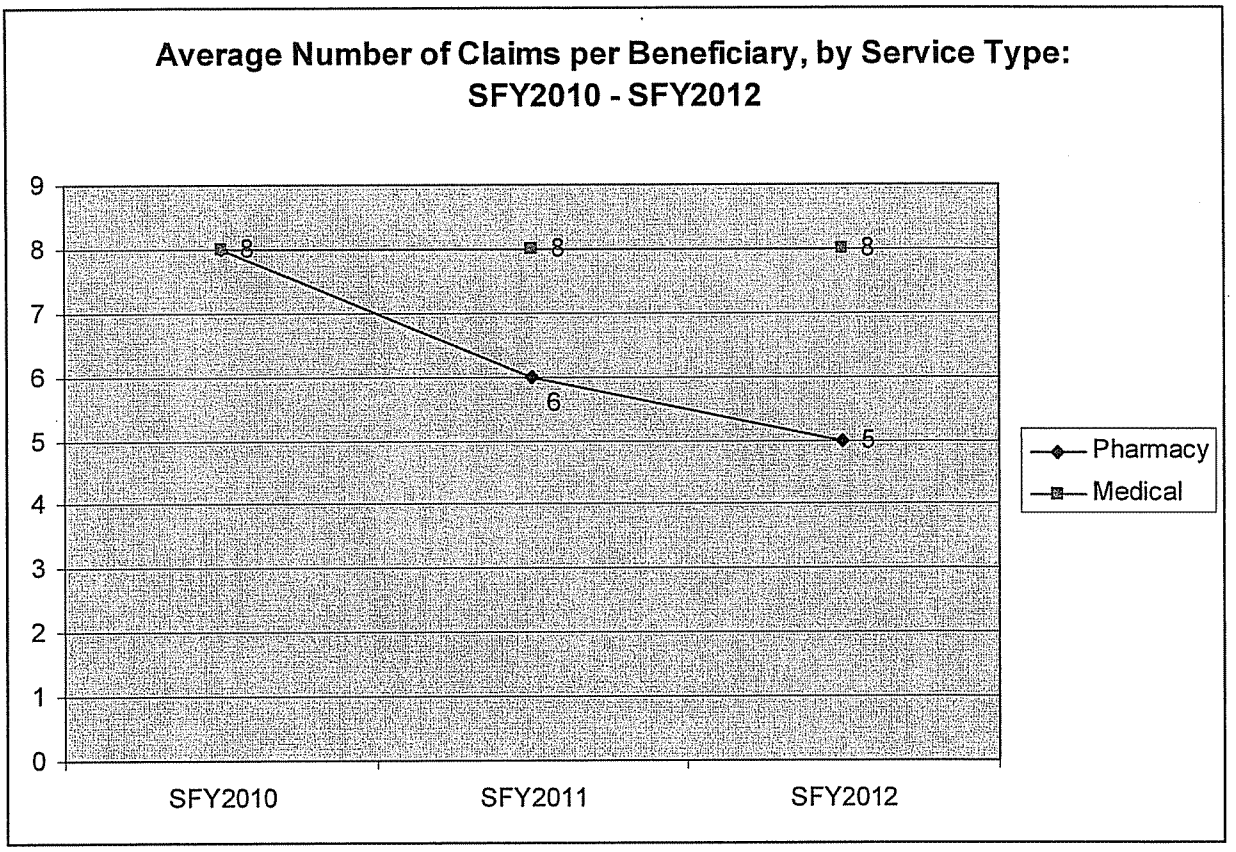


Figure 10 shows the trend in the number of Health Choice beneficiary claims for both medical and pharmacy services over the past three State Fiscal Years. Utilization is relative to the number of beneficiaries enrolled. As **Table 8** in this report shows, the number of enrolled Health Choice beneficiaries ages 6 through 18 increased each year from SFY 2010 to SFY 2012, for a total of 6 percent. As enrollment increased, one would have anticipated an increase in the total number of beneficiary claims. In fact, the number of medical services claims did increase by 10 percent. Conversely, the total number of pharmacy claims decreased by 18 percent from SFY 2010 to SFY 2012.

Figure 10.

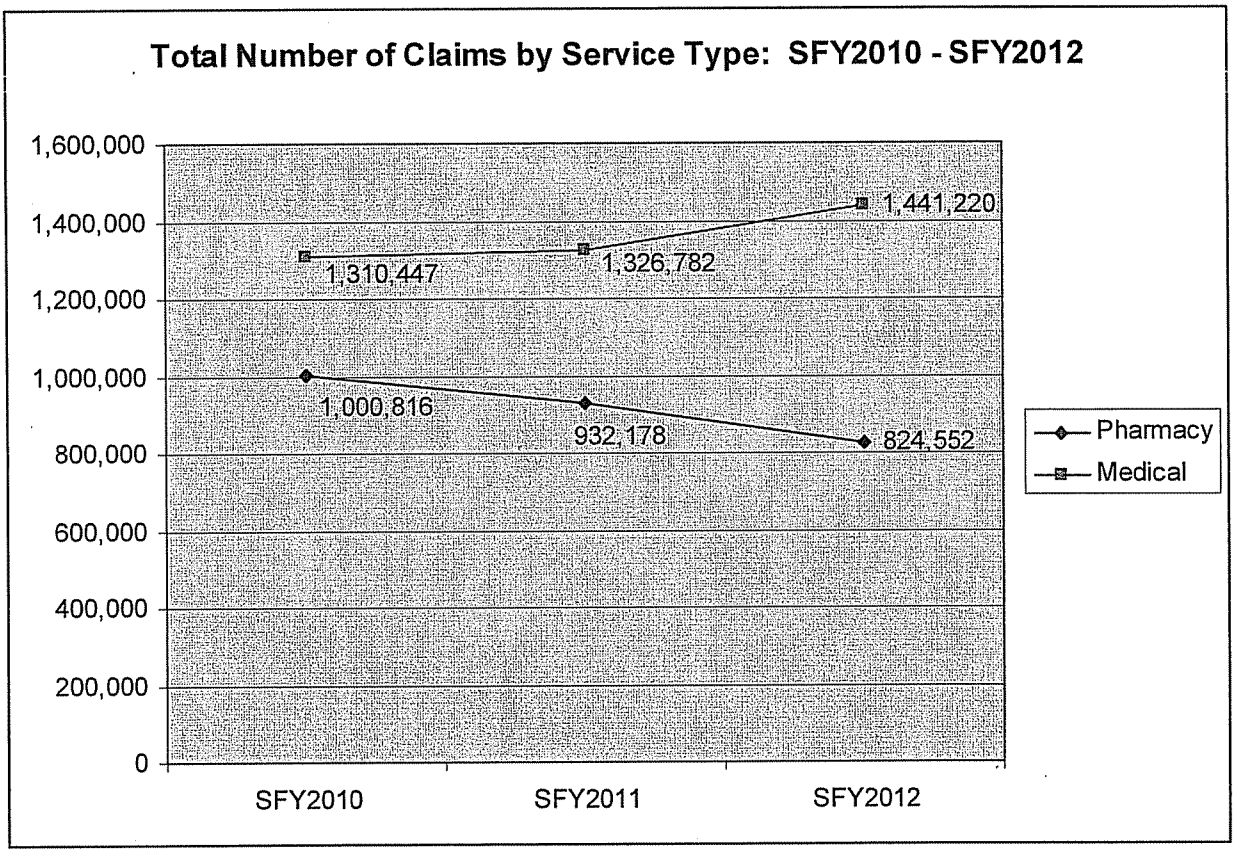
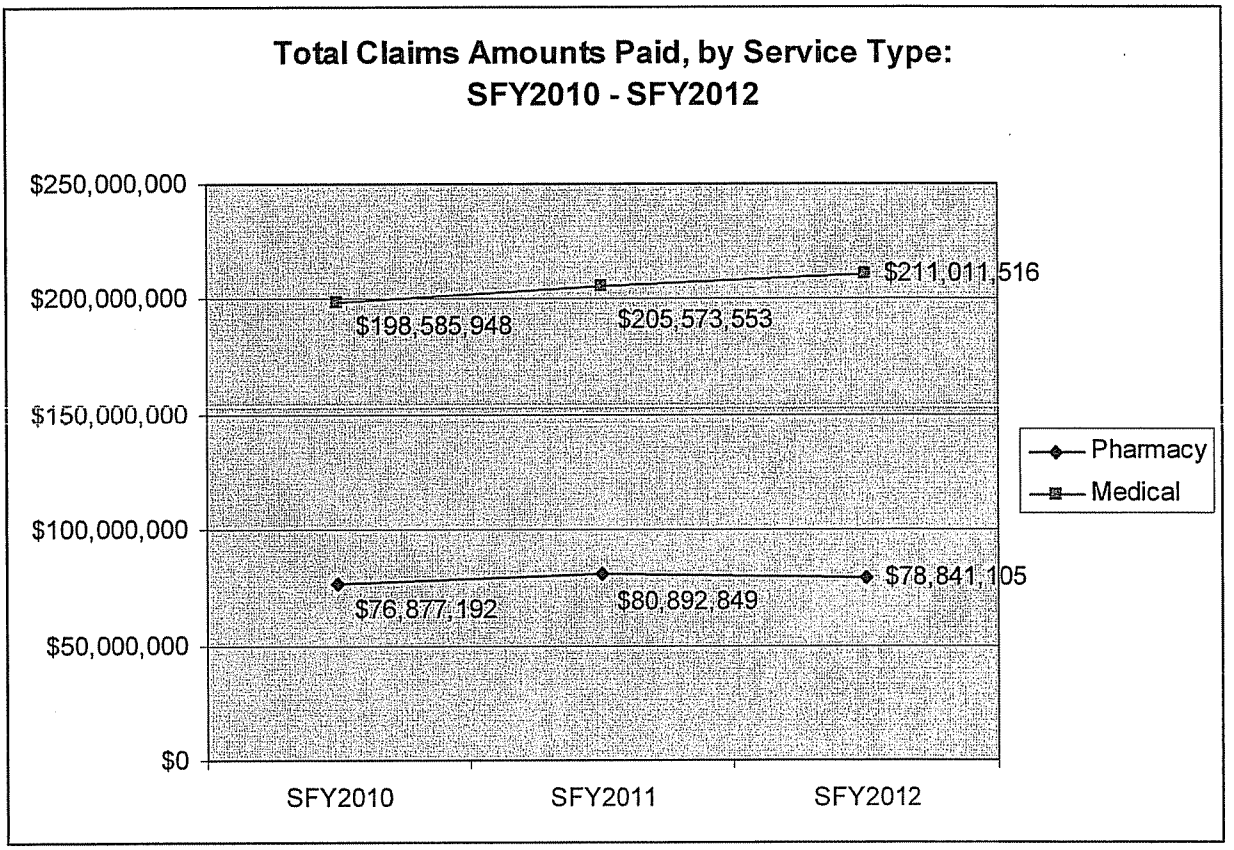


Figure 11 shows the trend in the total amount paid for Health Choice beneficiary claims for both medical and pharmacy services. The State paid 6 percent more for all medical services claims in SFY 2012 as compared to SFY 2010. This increase would be expected since there was an increase in the number of medical claims over the three year period. The State paid 2.5 percent more for all pharmacy services claims in SFY 2012 as compared to SFY 2010. Increased enrollment paired with increased cost were the most likely contributing factors to the trend since the total number of pharmacy claims actually decreased during the same time interval.

Figure 11.



Vaccination Claims

Health Choice covers age-appropriate immunizations pursuant to Title XXI Program federal regulations. Providers bill separately for vaccine administration—the act of giving vaccine to a child via an injection or orally—and the actual vaccine (antigen) administered. **Figure 12** shows a 19 percent increase in the total number of vaccine administration claims for Health Choice beneficiaries from SFY 2010 to SFY 2012. Health Choice enrollment increased by 6 percent over the past three State fiscal years, so the increase in the total number of claims for vaccine administration could be correlated with the overall increase in the number of beneficiaries. Successful outreach and beneficiary education could have been an additional contributing factor to the increase. **Figure 12** also shows a steady increase in the total number of vaccine claims for Health Choice beneficiaries from SFY 2010 to SFY 2012. The number of vaccine claims increased by 24 percent. The total number of vaccine claims per State Fiscal Year is higher than the total number of vaccine administration claims per State Fiscal Year for each respective year because multiple vaccines may be combined in one injection (one "vaccine administration").

Figure 12.

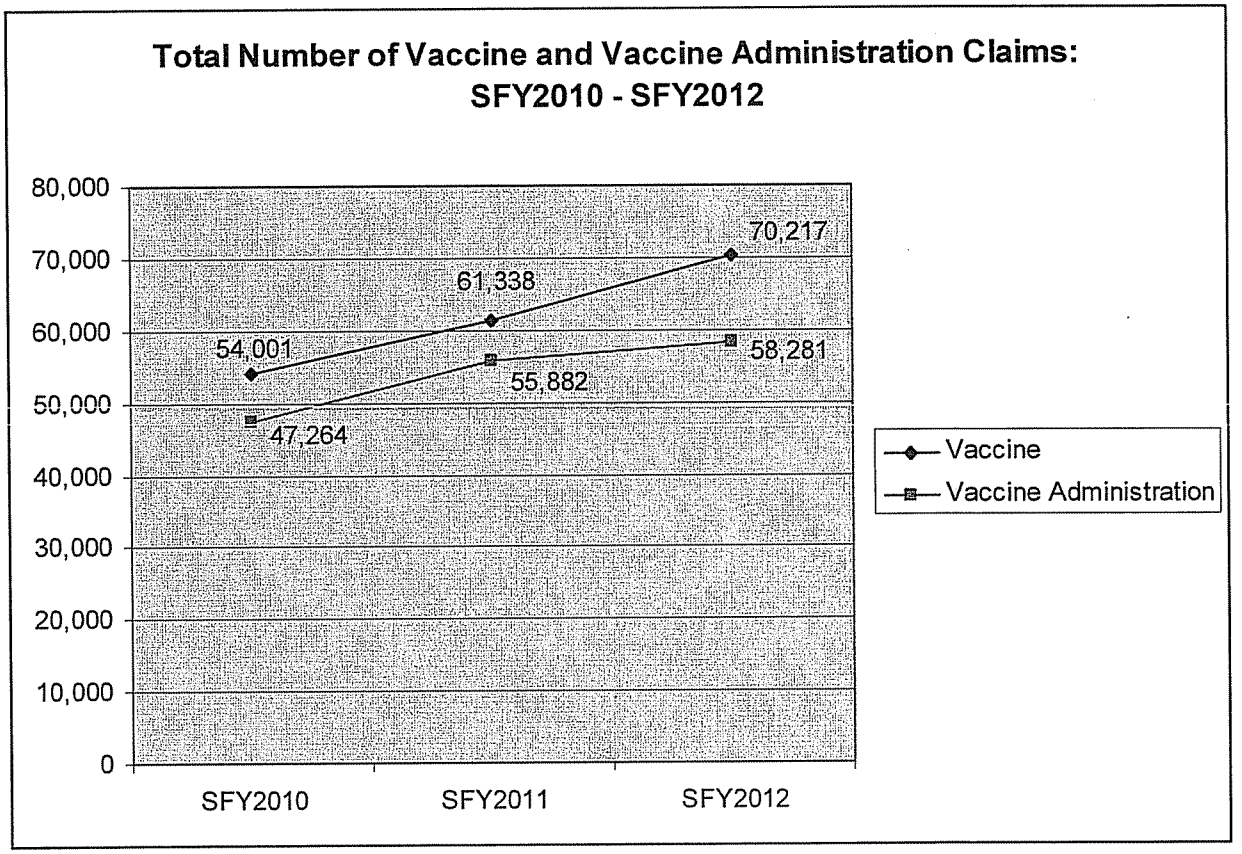


Figure 13 shows the trend in the program cost for vaccines and vaccine administration to Health Choice beneficiaries from SFY 2010 to SFY 2012. Over the three years, the total cost of vaccines increased by 36 percent and the total cost of vaccine administration increased by 21 percent.

In subsequent fiscal years, the State should see a decrease in the amount reimbursed to Health Choice providers for vaccine administration. As a result of the transition to Medicaid-equivalent coverage for Health Choice beneficiaries, Health Choice providers may no longer bill *per antigen* for vaccine administration. Rather, if multiple antigens are part of one injection, a provider may bill for only the one injection.

Figure 13.

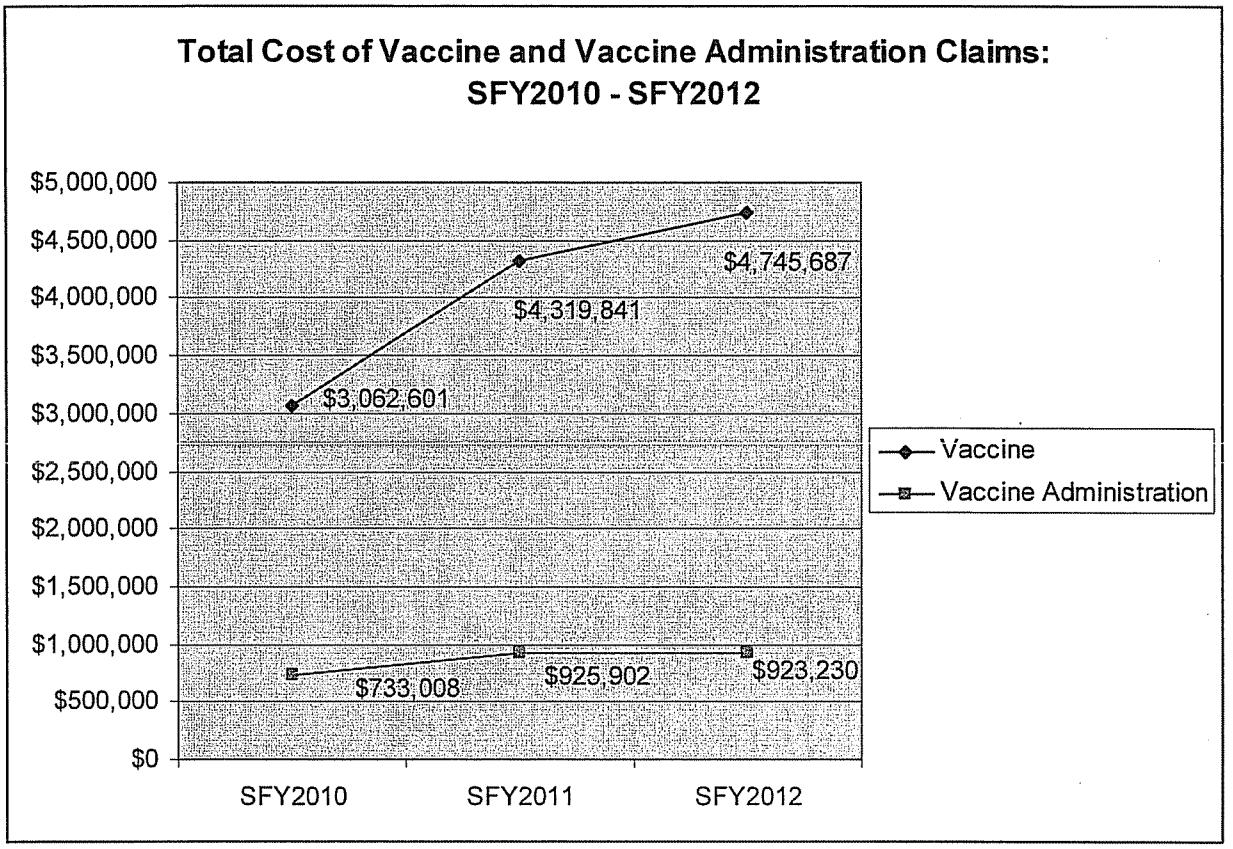


Figure 14 shows the number of vaccine claims by Health Choice beneficiary race and ethnicity. From SFY 2010 to SFY 2012, the number of claims increased among all groups. However, **Table 8** shows that program enrollment also increased each year from SFY 2010 to SFY 2012.

Figure 14.

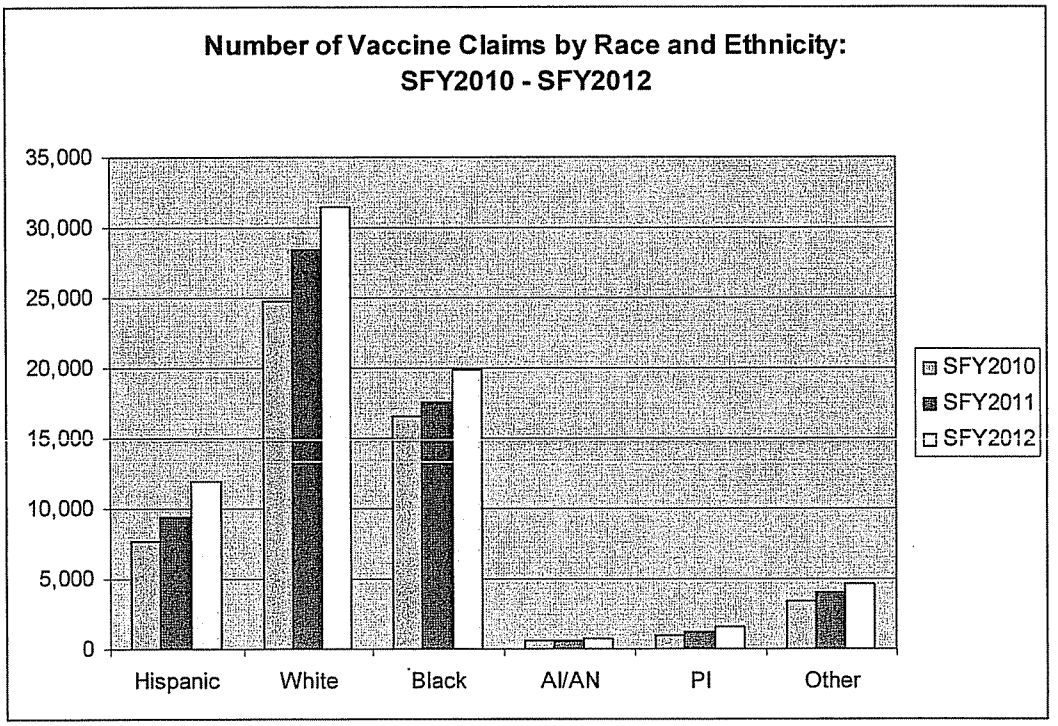
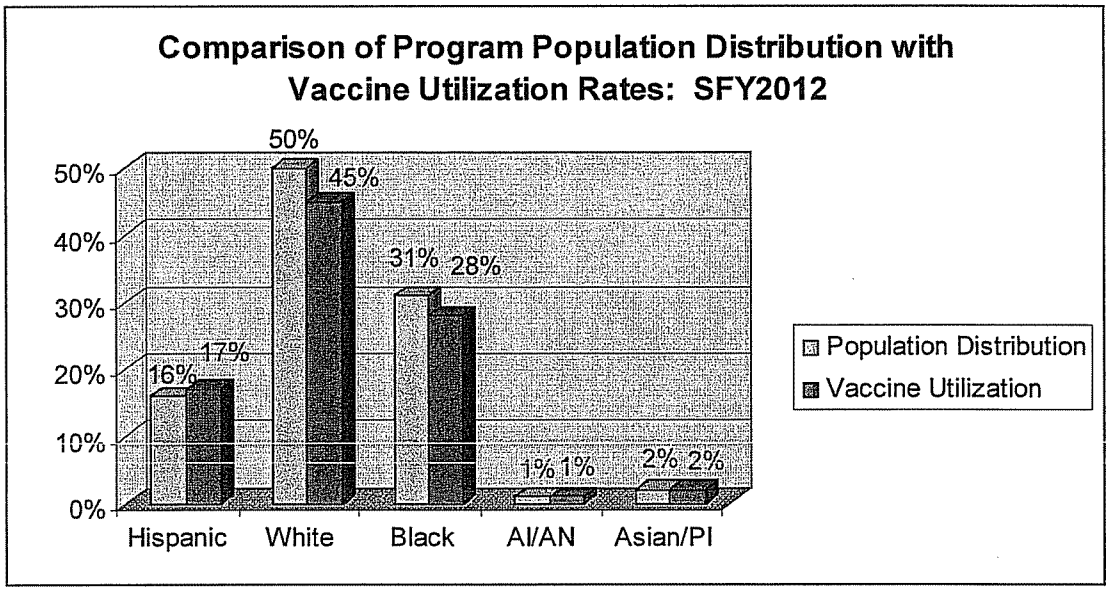


Figure 15 shows that the 2012 vaccine rates by race and ethnicity were reflective of the overall program enrollment rates by race and ethnicity. The comparable rates of enrollment and vaccine utilization by race and ethnicity indicate a positive trend in preventive health care utilization. However, the Division of Medical Assistance will continue to monitor this trend and any potential need for targeted outreach and education regarding age-appropriate immunizations. Program staff has also developed a *Health Choice Wellness Benefit Billing Guide* that includes well-child, vaccination, and preventive dental visit periodicity schedules to provide further age-appropriate screening guidance to Health Choice providers.

Figure 15.



Dental Claims

Figure 16 shows an 8 percent increase in preventive dental visits and a 7 percent increase in dental treatment visits among all Health Choice beneficiaries from SFY 2010 to SFY 2012.

Figure 16.

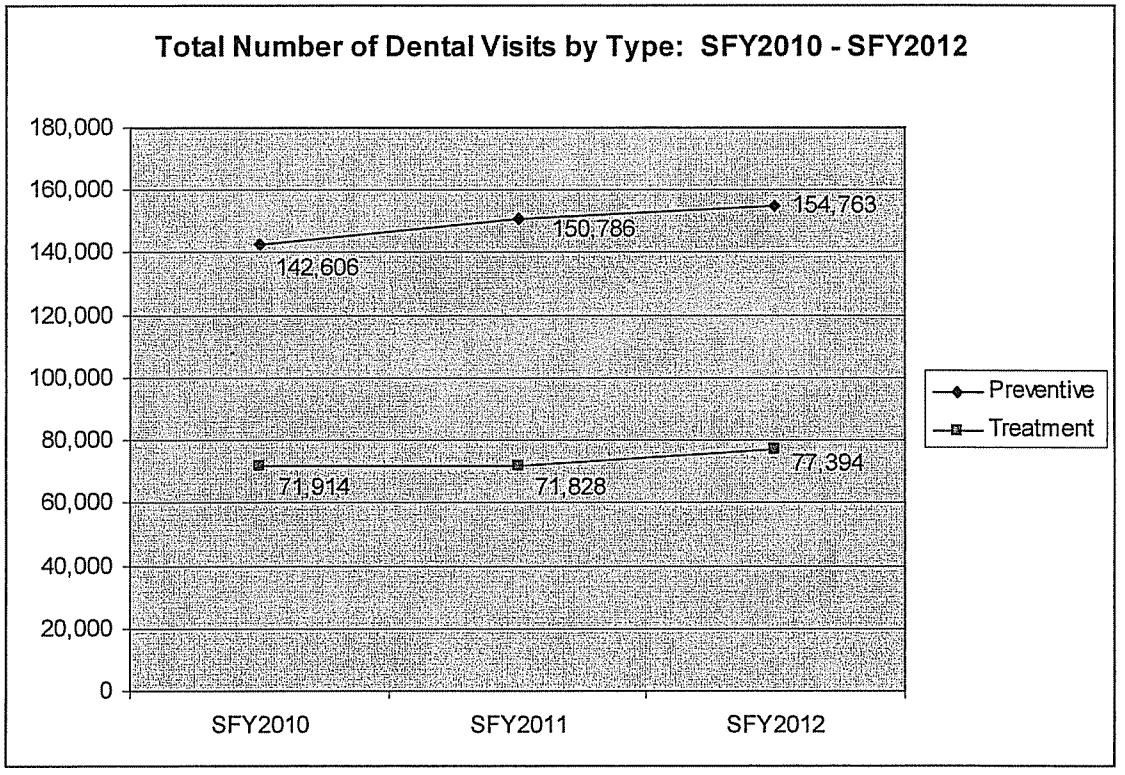


Figure 17 shows that the total cost of preventive dental visits increased by 3 percent in 2011, but then decreased by 7 percent in 2012 for a net lower cost at the end of the three years. Conversely, the cost of dental *treatment* visits decreased by 4 percent in 2011, but then increased by 10 percent in 2012 to yield the highest cost in three years.

Figure 17.

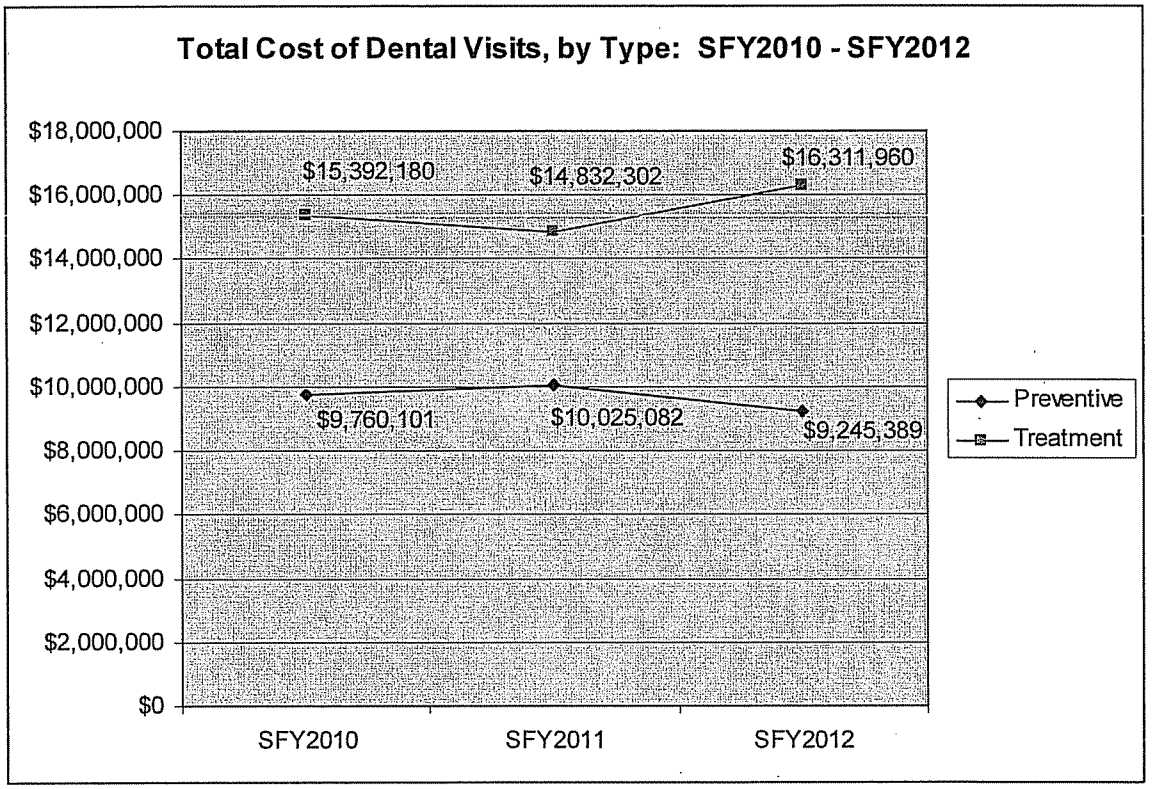
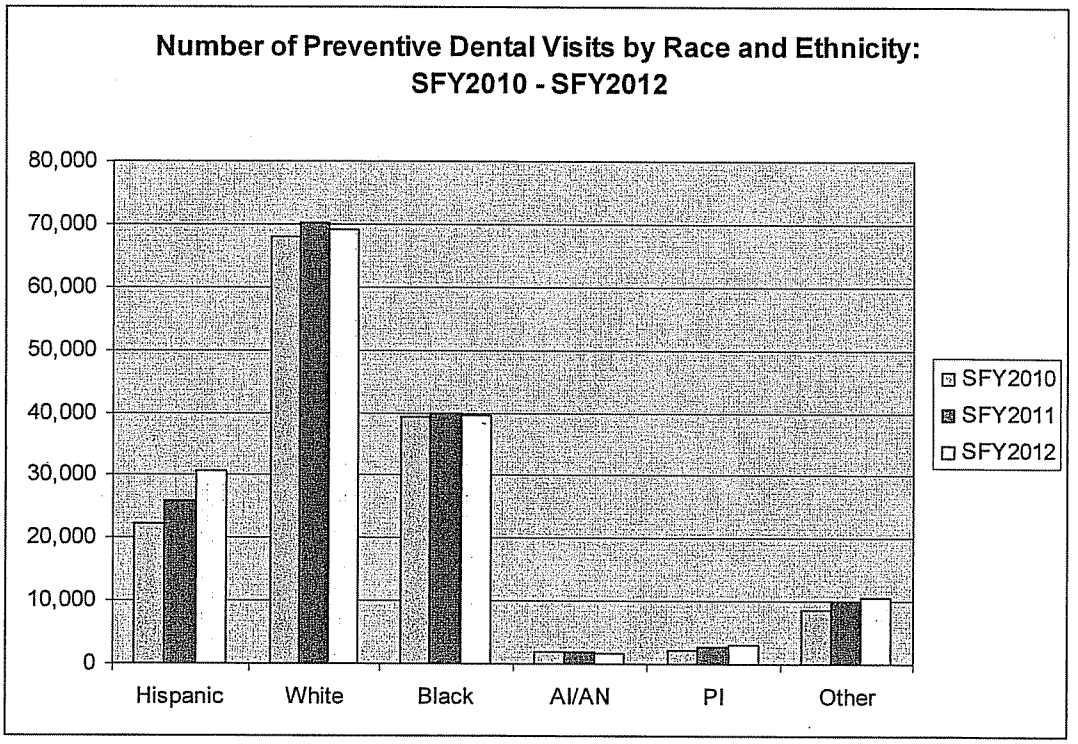


Figure 18 illustrates the three-year trend in preventive dental visit utilization, by race and ethnicity, from SFY 2010 to SFY 2012. Overall, Hispanic, Asian, and Pacific Islander Health Choice beneficiaries had increased utilization for the consecutive years, while American Indian and Alaska Native beneficiaries had decreased utilization. Black beneficiaries' utilization remained relatively stable with 39,326 visits in 2010 and 39,601 visits in 2012.

The three-year increases were 27 percent among Hispanics and 24 percent among Asian and Pacific Islanders. The three-year decrease among American Indian and Alaska Native beneficiaries was 10 percent. Preventive dental visit utilization among White beneficiaries increased by 4 percent in 2011, and then decreased by 2 percent in 2012, for a net increase of 2 percent at the end of the three years.

Figure 18.



LEGISLATIVE CHANGES TO THE PROGRAM FROM 2010 TO 2012

The State took steps in the 2010 legislative session to transfer the administration of Health Choice from the State Teachers and Employees Health Plan to the Division of Medical Assistance in the Department of Health and Human Services. However, the benefits coverage for the Program remained identical to what it had been under the State Health Plan. The 2011 legislative session mandated a transition of the benefits coverage to become equivalent to the Medicaid Program, which is also administered under the Division of Medical Assistance. G.S. 108A-70.21(b) states, "Except as otherwise provided for eligibility, fees, deductibles, co-payments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the North Carolina Medicaid Program except for the following:

1) No services for long-term care;
2) No non-emergency medical transportation;
3) No EPSDT; and
4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

In addition to the new equivalent coverage and exceptions, the 2011 Budget Bill repealed G.S. 108A-70.23. *Services for children with special needs established; definition; eligibility; services; limitation; recommendations; no entitlement.* Health Choice Providers now obtain prior approval for medically necessary services for Health Choice beneficiaries via combined medical coverage policies for Medicaid and NC Health Choice beneficiaries.

Effective July 25, 2011, a new Chapter 108C in the North Carolina General Statutes mandated standardized requirements for the regulation of Medicaid and Health Choice provider applications, screenings, enrollment, and auditing. Division of Medical Assistance oversight of providers in both programs helps streamline program administration, particularly within the Provider Enrollment and Program Integrity sections of the Division.

The 2012 General Session did not yield any legislative changes to the NC Health Choice program.

PROJECTIONS FOR CONTINUED PROGRAM FUNDING AND ADMINISTRATION

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) authorized Federal funding through September 30, 2013. The 2010 Patient Protection and Affordable Care Act (ACA) further authorized federal funding of Title XXI Children's Health Insurance Programs (CHIP) through September 30, 2015. The ACA also requires maintenance of eligibility for children through September 30, 2019. This means that North Carolina cannot adopt CHIP eligibility standards or methodologies that are more restrictive than those that were in effect when the ACA was enacted.

Effective January 1, 2014, states must have their Health Benefits Exchanges in place. Current ACA legislation prohibits CHIP (NC Health Choice) eligible children from participating in subsidized health insurance through an Exchange. However, States *are* required by 42 U.S.C. § 2101(b)(3)(B) to offer comparable plans within an Exchange. In the coming years, if federal funding is no longer authorized for CHIP programs beyond September 30, 2015, previously eligible children can then shift to the comparable, subsidized plan in an Exchange.

Title XXI dollars also pay for children ages 0 – 5 enrolled in the existing North Carolina Medicaid Expansion. North Carolina therefore receives the enhanced Title XXI Federal Medical Assistance Percentage (eFMAP) for these beneficiaries. The eFMAP in SFY 2012 was 75.7 cents of every dollar spent on the Health Choice program, as compared to the Federal Medical Assistance Percentage of 65.3 cents for every dollar spent on the Medicaid Program. The balance of each dollar comes from State appropriations. Medicaid is an entitlement program that must enroll all eligible applicants regardless of the cost to the State. However, Health Choice enrollment can be capped based on a fixed appropriations amount. Medicaid Expansion beneficiaries live in families with incomes of 186 to 200 percent of FPL for ages 0 to 12 months, and 134 to 200 percent for ages 13 months to 5 years. **Table 7** shows that in SFY 2012, more than 52,000 children were enrolled in North Carolina's Medicaid Expansion program. The Expansion will continue under the current Health Choice State Plan Amendment that was approved by the Centers for Medicare and Medicaid Services in October 2012.

As there were no legislative changes to Health Choice program administration in the 2012 General Session, the Division of Medical Assistance, DHHS, will continue to manage North Carolina's Medicaid and Health Choice programs in SFY 2013.

RESOURCES

- The Division of Medical Assistance NC Health Choice Website continues to be a primary resource for providers, beneficiaries, professionals, administrators, and the public. See: http://www.ncdhhs.gov/dma/healthchoice/index.htm.

- The NC Health Choice Program's CMS-approved, State Plan Amendment is available at: http://www.ncdhhs.gov/dma/provider/Health_Choice_FINAL_SPA10_12212012.pdf

- The NC Health Choice beneficiary handbook of benefits coverage is available at: http://www.ncdhhs.gov/dma/pub/0812_famchld.pdf.

- Individual medical coverage policies for both providers and beneficiaries are available at: http://www.ncdhhs.gov/dma/mp/index.htm.

- The *Basic Medicaid and NC Health Choice Billing Guide,* Section 3, contains information about NC Health Choice program administration for providers. See: http://www.ncdhhs.gov/dma/basicmed.

- The *NC Health Choice Wellness Benefit Billing Guide* contains medical coverage and provider billing information for well-child visits and screenings. See: http://www.ncdhhs.gov/dma/provider/library.htm.

- The NC Healthy Start Foundation provides online eligibility information and access to application forms. See: http://www.nchealthystart.org/public/childhealth/index.htm.

- The Centers for Medicare and Medicaid Services (CMS) requires the State of NC to annually update health benefits information for Medicaid and Health Choice recipients. You can view information specific to North Carolina at: http://www.insurekidsnow.gov/state/northcarolina/.