

**FRAMEWORK FOR THE ANNUAL REPORT OF  
THE STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

**Preamble**

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- ❖ Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs, **AND**
- ❖ Provide *consistency* across States in the structure, content, and format of the report, **AND**
- ❖ Build on data *already collected* by CMS quarterly enrollment and expenditure reports, **AND**
- ❖ Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

**FRAMEWORK FOR THE ANNUAL REPORT OF  
THE STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

State/Territory: North Carolina

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

**Gary Fuquay  
Acting Director  
NC Division of Medical Assistance**  
\_\_\_\_\_  
(Signature of Agency Head)

SCHIP Program Name(s): NC Health Choice for Children

SCHIP Program Type:

- SCHIP Medicaid Expansion Only  
 Separate Child Health Program Only  
 Combination of the above

Reporting

Period: FF 2003 Note: Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02.

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Submission Date: 12/29/2003

(Due to your CMS Regional Contact and Central Office Project Officer by January 1<sup>st</sup> of each year)  
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

## SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

- 1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility	From	0	% of FPL for conception to birth	0	% of FPL	From	0	% of FPL for conception to birth	0	% of FPL
	From	0	% of FPL for infants	0	% of FPL	From	185	% of FPL for infants	200	% of FPL
	From	0	% of FPL for children ages 1 through 5	0	% of FPL	From	133	% of FPL for children ages 1 through 5	200	% of FPL
	From	0	% of FPL for children ages 6 through 16	0	% of FPL	From	100	% of FPL for children ages 6 through 16	200	% of FPL
	From	0	% of FPL for children ages 17 and 18	0	% of FPL	From	100	% of FPL for children ages 17 and 18	200	% of FPL
Is presumptive eligibility provided for children?	<input type="checkbox"/>	No				<input checked="" type="checkbox"/>	No			
	<input type="checkbox"/>	Yes, for whom and how long?				<input type="checkbox"/>	Yes, for whom and how long?			
Is retroactive eligibility available?	<input type="checkbox"/>	No				<input checked="" type="checkbox"/>	No			
	<input type="checkbox"/>	Yes, for whom and how long?				<input type="checkbox"/>	Yes, for whom and how long?			
Does your State Plan contain authority to implement a waiting list?	Not applicable					<input type="checkbox"/>	No			
						<input checked="" type="checkbox"/>	Yes			
Does your program have a mail-in application?	<input type="checkbox"/>	No				<input type="checkbox"/>	No			
	<input type="checkbox"/>	Yes				<input checked="" type="checkbox"/>	Yes			
Can an applicant apply for your program over phone?	<input type="checkbox"/>	No				<input checked="" type="checkbox"/>	No			
	<input type="checkbox"/>	Yes				<input type="checkbox"/>	Yes			
Does your program have an application on your website that can be printed, completed and mailed in?	<input type="checkbox"/>	No				<input type="checkbox"/>	No			
	<input type="checkbox"/>	Yes				<input checked="" type="checkbox"/>	Yes			
Can an applicant apply	<input type="checkbox"/>	No				<input checked="" type="checkbox"/>	No			

**SCHIP Medicaid Expansion Program**

**Separate Child Health Program**

for your program on-line?

Yes – please check all that apply

Signature page must be printed and mailed in

Family documentation must be mailed (i.e., income documentation)

Electronic signature is required

Yes – please check all that apply

Signature page must be printed and mailed in

Family documentation must be mailed (i.e., income documentation)

Electronic signature is required

No Signature is required

Does your program require a face-to-face interview during initial application

No

Yes

No

Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?

No

Yes  
 Note: this option requires an 1115 waiver  
 Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6

Specify number of months | 0

No

Yes  
 Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6

Specify number of months | 0

Does your program provides period of continuous coverage regardless of income changes?

No

Yes

Specify number of months | 0

Explain circumstances when a child would lose eligibility during the time period in the box below

No

Yes

Specify number of months | 12

Explain circumstances when a child would lose eligibility during the time period in the box below

Does your program require premiums or an enrollment fee?

No

Yes

Enrollment Fee | \$ | 0

Premium Amount | \$ | 0

Yearly cap | \$ | 0

Briefly explain fee structure in the box below

fldQue42

No

Yes

Enrollment Fee | \$ | 50 per one child, 100 two or more

Premium Amount | \$ | 0

Yearly cap | \$ | 0

Briefly explain fee structure in the box below

This applies only to those over 150% fpl

Does your program impose copayments or coinsurance?

No

Yes

No

Yes

Does your program require an assets test?

No

Yes

If Yes, please describe below

No

Yes

If Yes, please describe below

Is a preprinted renewal

No

No

	SCHIP Medicaid Expansion Program	Separate Child Health Program
Form sent prior to eligibility expiring?	Yes, we send out form to family with their information precompleted and <input type="checkbox"/> ask for confirmation  <input type="checkbox"/> do not require a response unless income or other circumstances have changed	Yes, we send out form to family with their information precompleted and <input type="checkbox"/> ask for confirmation  <input type="checkbox"/> do not require a response unless income or other circumstances have changed

2. Are the income disregards the same for your Medicaid and SCHIP Programs?  Yes  No

3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs?  Yes  No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b) Application	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
c) Benefit structure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d) Cost sharing structure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e) Cost sharing collection process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f) Crowd out policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
g) Delivery system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
i) Eligibility levels / target population	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
j) Eligibility redetermination process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
k) Enrollment process for health plan selection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
l) Family coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
m) Outreach	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

n) Premium assistance

o) Prenatal eligibility expansion

p) Waiver populations (funded under title XXI)

Parents

Pregnant women

Childless adults

q) Other – please specify

a. fldQue93

b. fldQue96

c. fldQue99

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>x</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>x</b>

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>x</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>x</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>x</b>

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. For each topic you responded yes to above, please explain the change and why the change was made, below.

<p>a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)</p>	<p>The NC General Assembly added an additional appeals point for consumers: The NC Department of Insurance, patient's rights section. It opens an additional avenue of appeal of claims denial and provides the same protections for NCHC children as managed care patients have.</p>
<p>b) Application</p>	<p>The application has been modified to make it more reader friendly as a result of focus group and language readability testing. It is now four pages long with more white space and larger type, easier reading.</p>
<p>c) Benefit structure</p>	
<p>d) Cost sharing structure</p>	
<p>e) Cost sharing collection process</p>	
<p>f) Crowd out policies</p>	
<p>g) Delivery system</p>	
<p>h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)</p>	
<p>i) Eligibility levels / target population</p>	
<p>j) Eligibility redetermination process</p>	
<p>k) Enrollment process for health plan selection</p>	
<p>l) Family coverage</p>	
<p>m) Outreach</p>	<p>Because enrollment is at capacity, and the program is fee for service, the state is moving outreach to a mode to encourage more appropriate use of services so that the dollars may be stretched to cover more children while reducing inappropriate overusage of providers.</p>
<p>n) Premium assistance</p>	
<p>o) Prenatal eligibility expansion</p>	
<p>p) Waiver populations (funded under title XXI)</p>	
<p>Parents</p>	
<p>Pregnant women</p>	
<p>Childless adults</p>	
<p>q) Other – please specify</p>	

a.	
b.	
c.	

## SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program.  
 Column 2: List the performance goals for each strategic objective.  
 Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Specify if the strategic objective listed is new/revised or continuing, the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

*Note: If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<b>Objectives related to Reducing the Number of Uninsured Children</b>		
To enroll the maximum number of children in NC Health Choice for Children.	Based on estimates from the NC Institute of Medicine we aim to enroll a total of 100,000 in 03 105,000 in 04, 110,000 in 05, 115,000 in 06 and 120,000 in 07, 125,000 in 08	New/Revised <input checked="" type="checkbox"/> Continuing <input type="checkbox"/>
		Data Sources: NC Institute of Medicine allowed estimates of total eligibles for SCHIP at somewhere between 125,000 and 165,000.
		Methodology: Based on Adjusted CPS data Progress Summary: As of the end of ffy 03 there were 100,819 children enrolled.
<b>Objectives Related to SCHIP Enrollment</b>		
To maximize SCHIP resources to assure maximum enrollment without freezing for new enrollees if at all possible	New family friendlier application form, more notices for reenrollment, education for families on more appropriate use of emergency rooms	New/Revised <input checked="" type="checkbox"/> Continuing <input type="checkbox"/>
		Data Sources: Monthly enrollment reports and reenrollment reports
		Methodology: monitoring by state and counties Progress Summary: No freeze in fy 2003
<b>Objectives Related to Increasing Medicaid Enrollment</b>		
Demonstrate increased numbers of enrollees in state SOBRA equivalent program	Comparison of 1998 to end of ffy 03 and ffy 02 compared to 03 to see if growth occurs	New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/>
		Data Sources: Monthly pull night reports
		Methodology: compare October 98 to October 03 and October 02 to October 03

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Progress Summary: Increased by 133,907 since 98; increased by 22,362 in ffy 03
<b>Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)</b>		
Maintain high usage of well child visits. Reduce use of emergency rooms	Meet HEDIS like measures for services. Assess ongoing er usage through BCBS utilization reports	New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/> Data Sources: Paid Claims Data Methodology: Computer run by cpt code Progress Summary: Well child visits above 95 percent for all ages. Raking 38 <sup>th</sup> out of top 100 cpt codes for expenditure. ER usage moderates.
<b>Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)</b>		
Maintain high rate of childhood immunizations.	Using universal immunization bank for state, determine immunization rates. Use immunization rates by first grade (age 2 reflects Medicaid not SCHIP data)	New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/> Data Sources: Immunization data bank Methodology: compare SCHIP kids to immunization data. Progress Summary: Children 99.5% immunized
<b>Other Objectives</b>		
fldQue132	fldQue133	New/Revised <input type="checkbox"/> Continuing <input type="checkbox"/> Data Sources: Methodology: Progress Summary:

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?  
Parent surveys. Ongoing satisfaction with program
  
3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?  
More parent satisfaction surveys through research universities.
  
4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special health care needs or other emerging health care needs? What have you found?  
The results of a longitudinal study were published in January, 2003: "A Cross-Insurance Comparison of North Carolina children with Special Health Care Needs." The study, by the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, looked at access to health care services for special needs children in NC Health Choice for Children, NC Medicaid and NC Teachers and State Employees Major

Medical Plan. It found that: NC Health Choice “program appears to provide better access to services for children with special health care needs than does the Medicaid program, and NCHC parents often report access that is comparable to that of (The State Employees Health Plan). However, it is not possible to separate out the relative effects on access to care that come from the general willingness of providers to serve low-income children, and influence of provider reimbursement rates that affect provider willingness . . . Regardless, parents report that health insurance is an essential component in their efforts to keep their children healthy.”

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program’s performance. Please list attachments here and summarize findings or list main findings.
  - Blue Cross Blue Shield of North Carolina Utilization Report—Overview of use of services by NC Health Choice members showing areas of increase or decrease in utilization.
  - NC Institute of Medicine Report—Detailed examination of NC Health Choice services and how best to redesign the program to maximize costs. Response to request from the NC General Assembly to examine feasibility of Medicaid look-alike. Transitioning to a Medicaid program was rejected. Modifications in the program to make it a combo program was recommended (later rejected by the NC General Assembly. Program now stands as originally designed.
  - Report of the Cecil B. Sheps Center on comparison of services for Children With Special Health Care Needs among NC Health Check, Medicaid and the State Employees Health Plan.
  - New outreach materials highlighting Spanish speaking materials. (attached in hard copy)
  - Web links to appropriate support data:
    - Website for local outreach coalitions: <http://www.nchealthystart.org/outreach/index.html>
    - Website for NC Employment Security Commission Data: <http://www.ncesc.com/lmi>
    - Website for NC Institute of Medicine: <http://www.nciom.org> --location of Institute of Medicine’s NC Health Choice Report
  - Back up to budget materials.

## REPORTING OF NATIONAL PERFORMANCE MEASURES

The Centers for Medicare & Medicaid Services (CMS) convened the Performance Measurement Partnership Project (PMPP) as a collaborative effort between Federal and state officials to develop a national set of performance measures for Medicaid and the State Children's Health Insurance Programs (SCHIP). CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001 and the Medicaid Final Rules of June 14, 2002 on managed care.

The PMPP's stated goal is to create a short list of performance measures relevant to those enrolled in Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of some 19 measures, the PMPP group trimmed the list to the following seven core measures (SCHIP states should report on all applicable measures for covered populations to the extent that data is available):

- Well child visits for children in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Comprehensive diabetes care (hemoglobin A1c tests)
- Children's access to primary care services
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

Work remains to resolve technical issues related to implementing the collection, analysis, and reporting of the measures. If your State currently has data on any of these measures, please report them using the format below. Indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

<b>Well child visits for children in the first 15 months of life</b>		
NCHC has five children that meet HEDIS criteria for this standard. Therefore there is not enough to report on this criteria.		Data Sources:
		Methodology:
		Progress Summary:
<b>Well child visits in the 3rd, 4th, 5th, and 6th years of life</b>		
	3814 screens 6,872 eligibles	Data Sources: paid claims cy 2002
		Methodology: HEDIS 2003 requirements
		Progress Summary: 55.59%
<b>Use of appropriate medications for children with asthma</b>		
fIdQue382	fIdQue383	Data Sources: paid claims

		Methodology: see attached
		Progress Summary: 65.84%
<b>Comprehensive diabetes care (hemoglobin A1c tests)</b>		
NA	NA	Data Sources: fldQue389
		Methodology: fldQue390
		Progress Summary: fldQue391
<b>Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)</b>		
Children's Access to Primary Care Practitioners 12-24 months	57.4 screens 59.3 eligibles	Data Sources: paid claims
		Methodology: use of HEDIS 2003
		Progress Summary: 96.8%
<b>Adult access to preventive/ambulatory health services</b>		
NA	NA	Data Sources: NA
		Methodology: NA
		Progress Summary: NA
<b>Prenatal and postpartum care (prenatal visits)</b>		
NA	NA	Data Sources:
		Methodology:
		Progress Summary

### **SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION**

#### **ENROLLMENT**

1. Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4<sup>th</sup> quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).

SCHIP Medicaid Expansion Program (SEDS form 64.21E)	Separate Child Health Program (SEDS form 21E)
<u>0</u>	<u>149,981</u>

2. Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.

The information we have is not based on hard evidence but on modified CPS information. The economy in North Carolina remains poor and newspapers are full of stories of plant closings and insurance loss. There is no objective survey, however, to track that information. Information on NCHC is taken by the Employment Security Commission to plant closings meetings and is discussed with employees. Current estimates of the numbers of children potentially eligible for the program who remain uninsured vary from 5,000 to 60,000.

3. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. **(States with only a SCHIP Medicaid Expansion Program, please skip to #4)** As seen in the Strategic Objectives Related to Increasing Medicaid Enrollment. We have monitored our Medicaid Infants and Children (SOBRA equivalent) enrollment since NC Health Choice began. Originally we were told to expect a total of some 68,000 “woodwork” children in the state who might add to the Medicaid rolls. Since NC Health Choice began in October of 1998, an additional 133,907 children have been added to the Medicaid Infants and Children program; 22,362 were added during ffy 2003 alone. This estimate is based on pull night numbers compiled each month to allow apples to apples comparisons.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?

Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State’s progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

No, skip to the Outreach subsection, below

Yes, please provide your new baseline And continue on to question 5  
100,000

5. On which source does your State currently base its baseline estimate of uninsured children?

The March supplement to the Current Population Survey (CPS)

A State-specific survey

A statistically adjusted CPS

Another appropriate source

A. What was the justification for adopting a different methodology? CPS numbers have historically reported fewer children below 200% of the federal poverty level than are actually enrolled in Medicaid. We adjusted the CPS numbers according to actual enrollment in Medicaid.

B. What is the State’s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

NC experts do not believe that CPS numbers are correct. The only other data on which to base a guess is the number of children enrolled in NC Health Choice. The NC Institute of Medicine estimated that there were a total of 125,000 children eligible for the program and that these children might come into the program in increments of 5,000 over the next several years. With 100,000 in for sfy 03, 105,000 for sfy 04, 110,000 for sfy 05, 115,000 for sfy 06, 120,000 for sfy 07 and 125,000 for sfy 08. By 1 December 03, there were 105,000 children

enrolled in the program. We have no confidence in the estimated numbers of potential eligibles and no reliable methods to estimate. Researchers at the Cecil G. Sheps Center in Chapel Hill have told us that the actual number of eligible children for NC Health Choice probably ranges somewhere between 125,000 and 165,000, but they do not express confidence in this estimate. The NC Institute of Medicine suggested that we use the lower end of the estimate as our baseline and that we budget based on the idea of enrolling all those eligible over a period of five years.

C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

The original estimate of total number of children for NC Health Choice was 73,343. Because no program has ever enrolled 100% of its eligibles, the baseline for the program originally was 66,000 children. We expected to enroll 30,000 of those children in the first year of the program. At the end of the first year we had enrolled 51,321 children. The working estimated number of children was upped at the end of 2001 to 68,000 children. By the end of December of 2001, enrollment was over 72,000 children, therefore new enrollment was frozen. Once the freeze was lifted and program recovery began, enrollment reached 85,563 by October 1, 2002. By the end of September 2003, enrollment had reached 100,819. All of these numbers are based on pull-night, the lowest point for enrollment each month. If we use our initial baseline of 300,000 we are 200% higher, If we use our original total estimate of 66,000 children the enrollment is now 50% higher.

## OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

We have changed our outreach to emphasize the need for wise use of health care facilities. In addition we continue to hone in on minority populations

2. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Our absolute measure is that this program has been at capacity for several years. The NC General Assembly keeps raising the bar, and our population grows to meet it. Our effective strategy consists of locally based coalitions and the practice of testing outreach modifications in a county to test its effectiveness before going statewide. Local coalitions are also used as a continuous quality improvement function to provide feedback areas of the program that need improvement.

3. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

We have discovered that permitting minority groups to develop their own specific outreach strategy while we provide their paper materials has been extremely effective. We judge this by looking at the numbers of minority children enrolling.

## **SUBSTITUTION OF COVERAGE (CROWD-OUT)**

*All States must complete the following 3 questions*

1. Describe how substitution of coverage is monitored and measured.  
The third party recovery section of the Division of Medical Assistance runs a computer match for every child as to whether or not they have other health insurance. Children cannot have other health insurance in place when they enroll in the program. In the first 5 months following a change in policy from a two month waiting period of uninsurance to uninsurance upon enrollment, the computer run kept on children who had other health insurance immediately before enrolling has counted 87 cases.. In that time frame, over 100,000 children enrolled in the program.

2. Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?

See above. We do not perceive of substitution of coverage as a “real” issue. Parents report that there is no affordable private insurance available to this population. Many employers are dropping dependent coverage in an effort to control costs.

3. At the time of application, what percent of applicants are found to have insurance?

See above

*States with separate child health programs over 200% of FPL must complete question 4*

4. Identify your substitution prevention provisions (waiting periods, etc.).

NA

*States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.*

5. Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

NA

*States with waiting period requirements must complete question 6. (This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)*

6. Identify any exceptions to your waiting period requirement.

NA

## COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

Yes. NC has the same verification of income requirements

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.

We have one reapplication form for both Medicaid and SCHIP. If the family income changes so that the child is eligible for NC Health Choice, the child is enrolled in Health Choice. If a Health Choice child is eligible for Medicaid, the child is enrolled in Medicaid

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain

No. Medicaid has a provider network comprised of those agreeing to participate in a PCCM. NC Health Choice is a traditional indemnity program with any willing provider service.

## ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? *Check all that apply.*

- |                                     |  |   |
|-------------------------------------|--|---|
| <input checked="" type="checkbox"/> | Follow-up by caseworkers/outreach workers  |   |
| <input checked="" type="checkbox"/> | Renewal reminder notices to all families, <i>specify how many notices and when notified</i>                      |   |
|                                     | 3 beginning at the beginning of the 11 <sup>th</sup> month from the state. Another notice is sent by the county. |   |
| <input checked="" type="checkbox"/> | Targeted mailing to selected populations, <i>specify population</i>  | <u>Those whose 12 months continuous enrollment has only one month to go.</u>  |
| <input checked="" type="checkbox"/> | Information campaigns  |   |
| <input checked="" type="checkbox"/> | Simplification of re-enrollment process, <i>please describe</i>  | <u>Specific Simplified Reenrollment Form is mailed out with name and address</u>  |
| <input checked="" type="checkbox"/> | Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, <i>please describe</i>  | <u>We used our Robert Wood Johnson Covering Kids counties to conduct surveys regarding NC Health Choice and used the gathered data statewide.</u> |
| <input checked="" type="checkbox"/> | Other, <i>please explain</i>   |   |

2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

All have had some effectiveness. We are continually appraising our efforts with the goal toward improving the measures.

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or how many move?) If so, describe the data source and method used to derive this information.

We have an ongoing effort to find out why people disenroll. Unfortunately, the vast majority either move and cannot be found or give no reason for disenrollment. When the state froze the program for eight months and accrued a waiting list, the waiting list families were assessed. We found that many had gone into Medicaid, a few had found private health insurance. Some had aged out. Focus group studies have found that much of the disenrollment is temporary and caused by individuals who are very busy and fall behind on meeting their deadlines for a variety of reasons. These families usually reenroll at a later time or when someone is sick if there is no freeze imposed. During the freeze, we found that our reenrollment rates dramatically improved.

### **COST SHARING**

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Yes. We have found that failure to pay the enrollment fee has consistently been a top reason for failure to enroll in the program. Only 30 percent of our enrolled families are over 150% fpl and therefore required to pay an enrollment fee. Since this was first discovered several counties have taken steps to find willing foundations or charitable organizations willing to take up the cause of providing enrollment fees to those families who would not otherwise be able to afford them. This has resulted in "failure to pay enrollment" moving from first to third place in reasons for failure to enroll. The other reasons are "makes too much money," and "has health insurance or Medicare."

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

no

### **FAMILY COVERAGE PROGRAM UNDER TITLE XXI**

1. Does your State offer family coverage through a family coverage waiver as described in 42 CFR §457.1010?

Yes, briefly describe program  
below and continue on to question  2. No, skip to the Premium Assistance Subsection.

2. Identify the total State expenditures for family coverage during the reporting period.

fldQue174

3. Identify the total number of children and adults covered by family coverage during the reporting period. (Note: If adults are covered incidentally they should not be included in this data.)

\_\_\_\_\_ 0      Number of adults ever enrolled during the reporting period  
 \_\_\_\_\_ 0      Number of children ever enrolled during the reporting period

4. What do you estimate is the impact of family coverage on enrollment, retention, and access to care of children?
5. How do you monitor cost effectiveness of coverage? What have you found?

**PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN**

1. Does your State offer a premium assistance program using title XXI funds under any of the following authorities?

Note:

- Yes, check all that apply and complete each question for each authority.      **X** No, skip to Section IV.
- State
  - Family Coverage
  - Section 1115 Demonstration
  - Health Insurance Accountability & Flexible Demonstration
  - HIPP

2. Briefly describe your program (including current status, progress, difficulties, etc.)  
 fldQue369

3. What benefit package does the program use?  
 fldQue180

4. Does the program provide wrap-around coverage for benefits? For cost sharing?  
 fldQue181

5. Identify the total number of children and adults enrolled in the premium assistance program for whom title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

\_\_\_\_\_ 0      Number of adults ever enrolled during the reporting period

\_\_\_\_\_

0      Number of children ever enrolled during the reporting period

6. Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program. How was this measured?

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7. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

fldQue185

8. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

fldQue186

#### **SECTION IV: PROGRAM FINANCING FOR STATE PLAN**

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. *Note: This reporting period = Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02). If you have a combination program you need only submit one budget; programs do not need to be reported separately.*

#### **COST OF APPROVED SCHIP PLAN**

<b>Benefit Costs</b>	<b>Reporting Period</b>	<b>Next Fiscal Year</b>	<b>Following Fiscal Year</b>
Insurance payments	114,545,203	173,777,802	193,167,708
Managed Care	0	0	0
Per member/Per month rate @ # of eligibles	0	0	0
Fee for Service	0	0	0
<b>Total Benefit Costs</b>	114,545,203	173,777,802	193,167,708
<i>(Offsetting beneficiary cost sharing payments)</i>	0	0	0
<b>Net Benefit Costs</b>	114,545,203	173,777,802	193,167,708

#### **Administration Costs**

Personnel	107,835	105,922	107,841
General Administration	3,865,914	3,818,275	<b>4,364,559</b>
Contractors/Brokers (e.g., enrollment contractors)	0	0	0
Claims Processing	0	0	0
Outreach/Marketing costs	378,512	367,604	<b>460,153</b>

Other fldQue223	0	0	0
<b>Total Administration Costs</b>	4,352,261	4,291,801	<b>4,932,553</b>
<b>10% Administrative Cap</b> (net benefit costs ÷ 9)	12,727,245	19,308,645	<b>21,463,079</b>

<b>Federal Title XXI Share</b>	86,818,927	131,397,562	<b>146,594,193</b>
<b>State Share</b>	32,078,537	46,672,043	<b>51,506,068</b>

<b>TOTAL COSTS OF APPROVED SCHIP PLAN</b>	118,897,464	178,069,605	<b>198,100,261</b>
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fldQue242

2. What were the sources of non-Federal funding used for State match during the reporting period?

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations (such as United Way, sponsorship)
- Other (specify) fldQue244

**SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)**

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
	From	0	% of FPL to	0	% of FPL	From	0	% of FPL to	0	% of FPL
Children										
Parents										
Childless Adults										
Pregnant Women										

2. Identify the total number of children and adults ever enrolled in your SCHIP demonstration during the reporting period.

<u>          0          </u>	Number of <b>children</b> ever enrolled during the reporting period in the demonstration
<u>          0          </u>	Number of <b>parents</b> ever enrolled during the reporting period in the demonstration
<u>          0          </u>	Number of <b>pregnant women</b> ever enrolled during the reporting period in the demonstration
<u>          0          </u>	Number of <b>childless adults</b> ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration on enrollment, retention, and access to care of children?

fldQue265

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. *Note: This reporting period (Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02).*

<b>COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)</b>	<b>Reporting Period</b>	<b>Next Fiscal Year</b>	<b>Following Fiscal Year</b>
<b>Benefit Costs for Demonstration Population #1 (e.g., children)</b>			
Insurance Payments	0	0	0
Managed care	0	0	0
per member/per month rate @ # of eligibles	0	0	0
Fee for Service	0	0	0
<b>Total Benefit Costs for Waiver Population #1</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Benefit Costs for Demonstration Population #2 (e.g., parents)</b>			
Insurance Payments	0	0	0
Managed care	0	0	0
per member/per month rate @ # of eligibles	0	0	0
Fee for Service	0	0	0
<b>Total Benefit Costs for Waiver Population #2</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Benefit Costs for Demonstration Population #3 (e.g., pregnant women)</b>			
Insurance Payments	0	0	0
Managed care	0	0	0
per member/per month rate @ # of eligibles	0	0	0
Fee for Service	0	0	0
<b>Total Benefit Costs for Waiver Population #3</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total Benefit Costs</b>	<b>0</b>	<b>0</b>	<b>0</b>
(Offsetting Beneficiary Cost Sharing Payments)	0	0	0
<b>Net Benefit Costs</b> (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)	<b>0</b>	<b>0</b>	<b>0</b>
<b>Administration Costs</b>			
Personnel	0	0	0
General Administration	0	0	0
Contractors/Brokers (e.g., enrollment contractors)	0	0	0
Claims Processing	0	0	0
Outreach/Marketing costs	0	0	0
Other (specify) fldQue335	0	0	0
<b>Total Administration Costs</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>10% Administrative Cap</b> (net benefit costs ÷ 9)	<b>0</b>	<b>0</b>	<b>0</b>
<b>Federal Title XXI Share</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>State Share</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>TOTAL COSTS OF DEMONSTRATION</b>	<b>0</b>	<b>0</b>	<b>0</b>

fldQue354

**SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS**

1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

According to the NC Employment Security Commission the prolonged recession that began in NC in 2001 only began to show a slight increase of 1.5% in the state economic indicators in September 2003. Often referred to as a jobless recovery, over 47,000 jobs were lost through plant closings and layoffs during ffy 2003. Some employers that stayed open eliminated dependent benefits or increased out of pocket health care costs for workers. One large insurer, The State Employees Health Plan, decreased provider reimbursements, renegotiated all hospital contracts individually, upped copayments on medications and increased premiums on unsubsidized family coverage. Each of these economic indicators resulted in increased out of pocket costs for the workforce to maintain health care coverage for their children.

2. During the reporting period, what has been the greatest challenge your program has experienced?

The need to transform our outreach dollars from member recruitment to member education for wise use of the health care system has been a critical focus of the program. This is designed to help us reduce the cost of care and therefore have funds to cover more children. In addition, we have attempted to find and address the primary causes of escalating special needs costs. Isolating the costs to one behavioral health program and attempting to find ways to change the system to provide more cost effective and medically efficacious service has been the predominate challenge of ffy2003.

3. During the reporting period, what accomplishments have been achieved in your program?

The state avoided two potential freezes at the last minute and encouraged an independent, indepth study of the program by the NC Institute of Medicine. This study produced a package of legislative suggestions to the Governor and the NC General Assembly many portions of which were adopted as part of the effort to control costs. An internal result of the efforts to more systematically approach the budget process resulted in the decision to review budgets by quarter to assure that budget limitations were observed and to no longer measure budgets through an enrolled population proxy.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

The NC General Assembly has requested that all dollars be maximized. In depth analysis of program expenditures indicate that increasing behavioral health costs for 100 children have been the primary drivers of increased pmpm. Efforts to modify these services to make them better for the children and more cost effective will be one focus of the 2004 ffy. This is part of an overarching goal to focus on the provision of overall case /care management to both reduce inappropriate use of high cost services and to maximize children's health and utilization of preventive care.