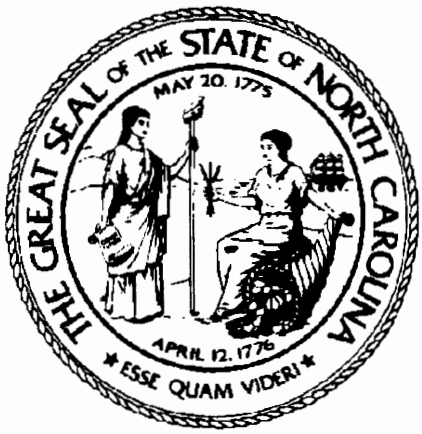
NC Health Choice for Children

Annual Report to the North Carolina General Assembly

State Fiscal Year 2010-2011



State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

dhhs

NC Health Choice for Children

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 (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 State Children's Health Insurance Program (SCHIP), the Health Choice Program for Children (hereafter referred to as Health Choice), provides comprehensive health care coverage for children of working families who earn too much to qualify for Title XIX (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 under the Program;
2. Number of Program applicants deemed eligible for Medicaid;
3. Number of applicants deemed eligible for the Program, by income level, age, and family size;
4. Number of applicants deemed ineligible for the Program 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 in the Program to date and for the immediately preceding fiscal year;
7. Total number of children enrolled in Medicaid through the Program application process;
8. Trends showing the 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:

- Program areas working most and least effectively
- Performance measures used to ensure Program 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 Program efficiency; and
- Recommended changes in the Program necessary to improve Program efficiency and effectiveness.

PROGRAM OVERVIEW

Title XXI State Children's Health Insurance Program

Title XXI of the federal Social Security Act provides federal funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children through the State Children's Health Insurance Program (SCHIP, 42 U.S.C. 1397a et seq.). Federal Medical Assistance Percentage (FMAP) funding is provided for SCHIP and adjusted annually; it accounted for approximately 75 percent of North Carolina's Title XXI health insurance coverage funding in SFY 2010-2011. State appropriations and other non-appropriated funds provided the remaining 25 percent. Unlike Medicaid, Health Choice is not an entitlement program and 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 State Child Health Program (Health Choice) and a Medicaid Expansion Group. Children in the Medicaid Expansion program receive the same benefit plan as children enrolled in the Medicaid Title XIX program, but North Carolina receives the Title XXI Program enhanced Federal Medical Assistance Percentage 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 recipient turns 19);
- live in a family with income between 101 percent and 200 percent of the Federal Poverty Level (FPL);
- 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; or
- 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 Group, there is an Extended Coverage option. 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.
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.

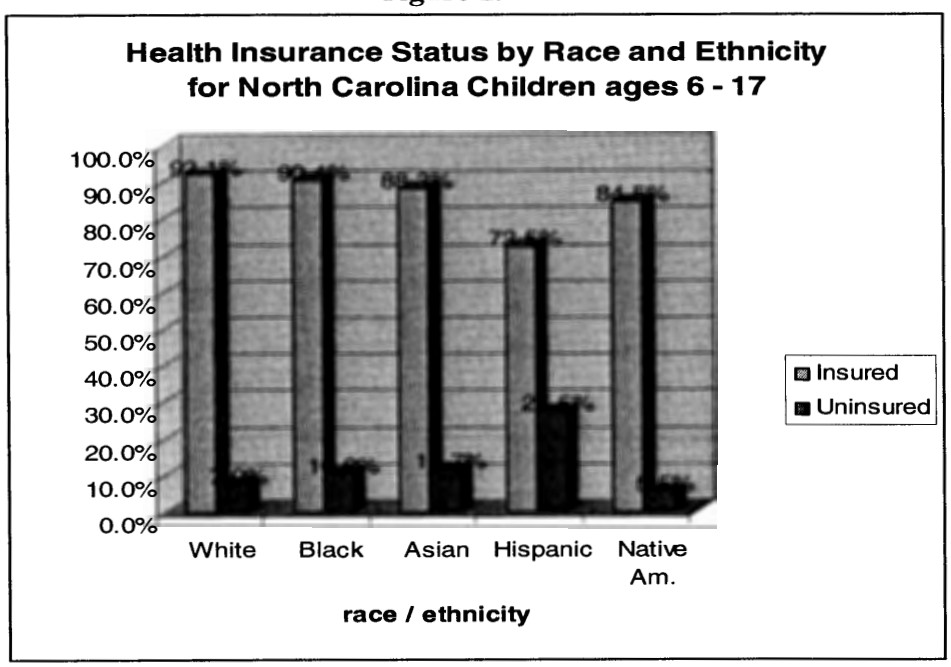
All other Health Choice eligibility requirements apply.

Uninsured Children in North Carolina

The State screens and enrolls uninsured eligible children in the Medicaid expansion program and the separate Child Health Insurance Program based on family size, countable gross income as a percentage of the Federal Poverty Level (FPL %), and age. The purpose of North Carolina's Title XXI plan is to ensure that every child in the state has access to an ongoing system of preventive health care. The program is designed to provide comprehensive health care coverage for children of working families who make too much to qualify for Title XIX and too little to afford private or employer-sponsored health insurance.

The Current Population Survey 2009 Annual Social and Economic Supplement estimated the number of children in North Carolina under age 19 living at or below 200 percent of the federal poverty level to be 1,009,000. Within this population, the number of children without health insurance and potentially eligible for Medicaid or Health Choice was estimated at 210,000. **Figure 1** illustrates insurance coverage by race and ethnicity in 2009 in North Carolina (*Source: U.S. Census Bureau American Community Survey*).

Figure 1.



In December 2010, the North Carolina Institute of Medicine (NCIOM) released a study examining the availability of and access to health care for all North Carolina residents. The study revealed that between 2008 and 2009, the percentage of uninsured individuals in North Carolina of all ages grew by 29 percent to 1.6 million. The NCIOM 2010 Child Health Report Card revealed that 11.5 percent of children of all income levels and 20.0 percent of children living below 200 percent of the Federal Poverty Level were uninsured in 2009. Despite the growing number of uninsured individuals and children of all incomes in North Carolina, the NCIOM 2010 Child Health Report Card documented a 26.6 percent *increase* in public health insurance coverage for children ages 0 – 18 from 2004 to 2009.

PROGRAM ELIGIBILITY

Applicants may enroll in person or by mail using a joint application for the Medicaid and Health Choice programs. Health Choice eligibility is determined by the county Department of Social Services (DSS) in the county in which the individual resides. DSS caseworkers facilitate on-site completion. 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];
- 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 him or her in Medicaid. If family income exceeds the Medicaid income limit and is at or below 200 percent of the federal poverty income level, and all other Title XXI Health Choice 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.

Applicant Demographics

Table 1 shows the distribution of eligible applicants by family size and income 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 recipients. Three-fourths of eligible applicants fall into the higher income sub-group.

Table 1: Eligible Children Ages 6 – 18 by Family Size and Income Level: SFY 2011

Family Size	101 – 150% FPL	151-200% FPL
1	4390	17,526
2	6560	24,590
3	4765	10,642
4	1647	2,645
5	323	475
6	78	120
7	7	14
8	16	7
9	0	0
TOTAL	**17,786**	**56,019**

Application Denials

There were 82,525 applications for Health Choice in SFY 2011. Denial of program applications may be based on the aforementioned program eligibility criteria. However, G.S. 108A-70.26(c) allows applicants to appeal eligibility determination decisions. **Table 2** below shows the reasons for denial of 937 applications in SFY 2011.

Table 2: SFY 2010-2011 Health Choice Application Denials by Reason

Reason for Application Denial	Number of Applications Denied
Administrative Denial*	529
Family's income too high	148
Applicant did not provide information needed to establish eligibility	34
Applicant did not pay the enrollment fee	18
Applicant has comprehensive health insurance or Medicare	15
Client already receiving assistance	14
Income exceeds level for family size	13
Step-parent's income too high	3
Client refused to cooperate in the application process	3
Client's medical expenses do not indicate client will qualify within certain period	2
Client didn't apply for unemployment insurance benefits to which client may be eligible	2
TOTAL	**937**

**Administrative denials include incidences when application forms were incomplete or needed to be corrected and re-keyed in the Eligibility Information System.*

Figure 2 illustrates the distribution of denied Health Choice applications by application site.

Figure 2.

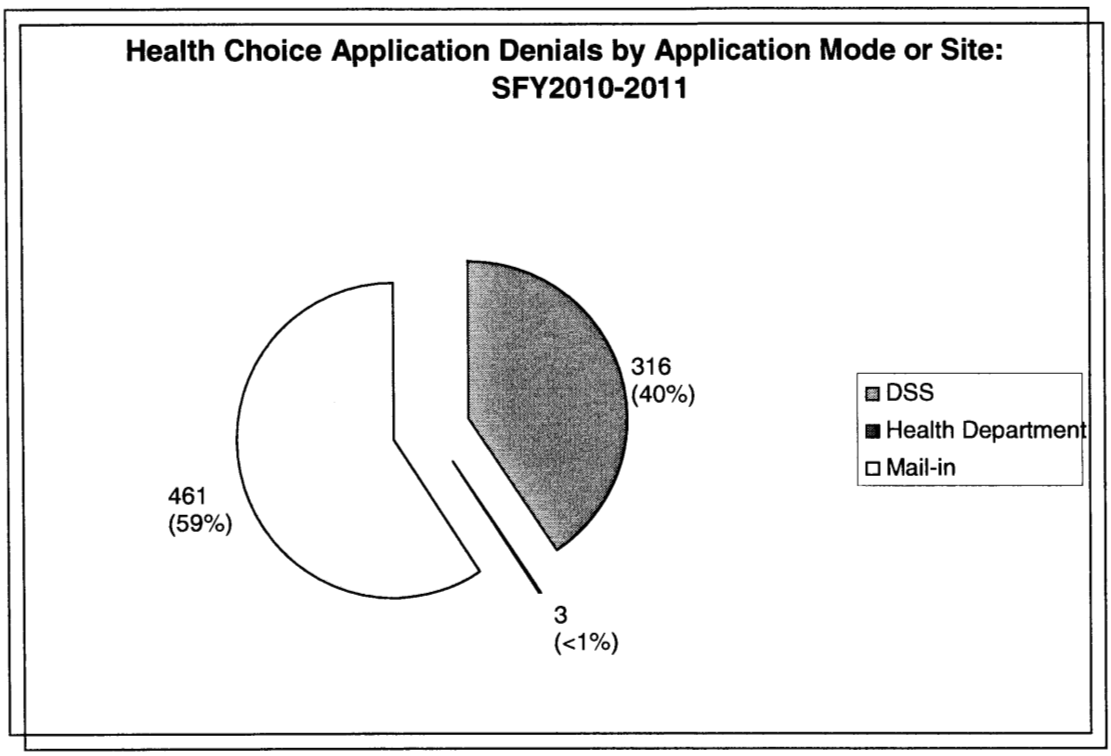
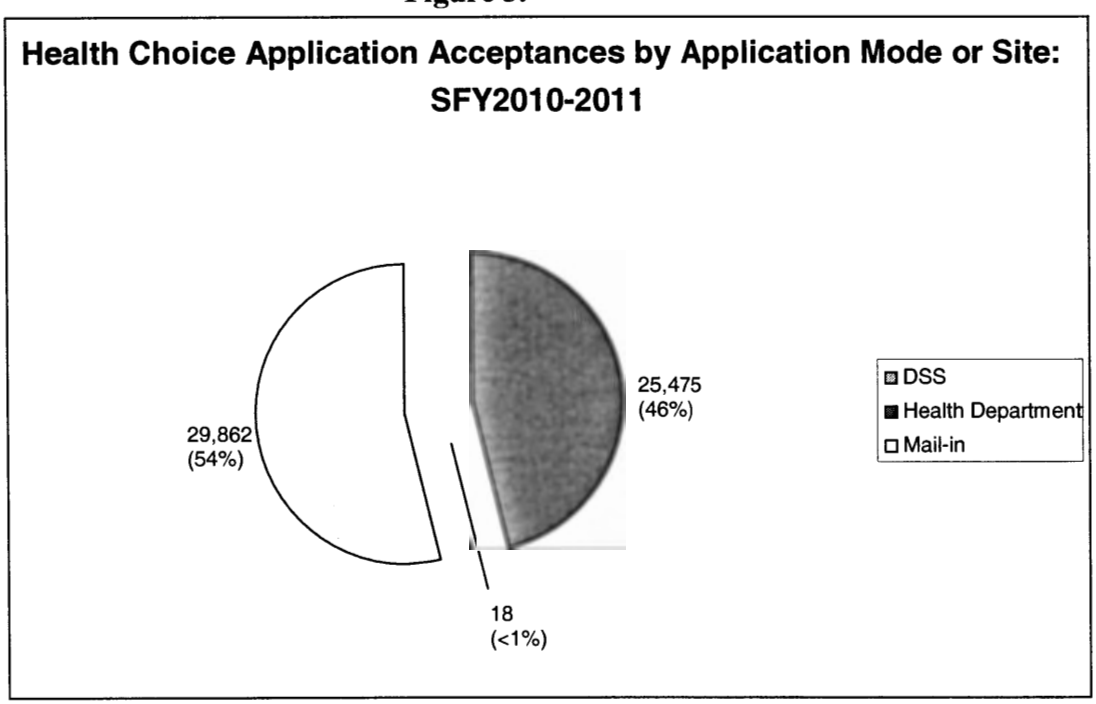


Figure 3 illustrates the distribution of accepted Health Choice applications by application site.

Figure 3.



PROGRAM ENROLLMENT

Pursuant to Session Law 2007-323 § 10.47, the Department of Health and Human Services may allow up to six percent (6%) enrollment growth annually. The cap in enrollment growth is based on the month of highest Program enrollment in the prior fiscal year. In the event that there are insufficient funds, the State stops new enrollments following public notice posted a minimum of 30 calendar days prior to the effective date of the freeze in enrollment. Currently, enrolled children who undergo a renewal re-evaluation during the freeze period receive a new 12- month period of continued enrollment if they meet all other eligibility requirements

Average monthly enrollment in Health Choice for SFY 2010-2011 was 143,317. **Figure 4** shows the distribution of Health Choice applicants by age. Children ages 6 – 9 years comprised 32 percent of recipients; children ages 10 – 14 comprised 40 percent of recipients, and children ages 15 – 18 comprised 28 percent of recipients.

Figure 4.

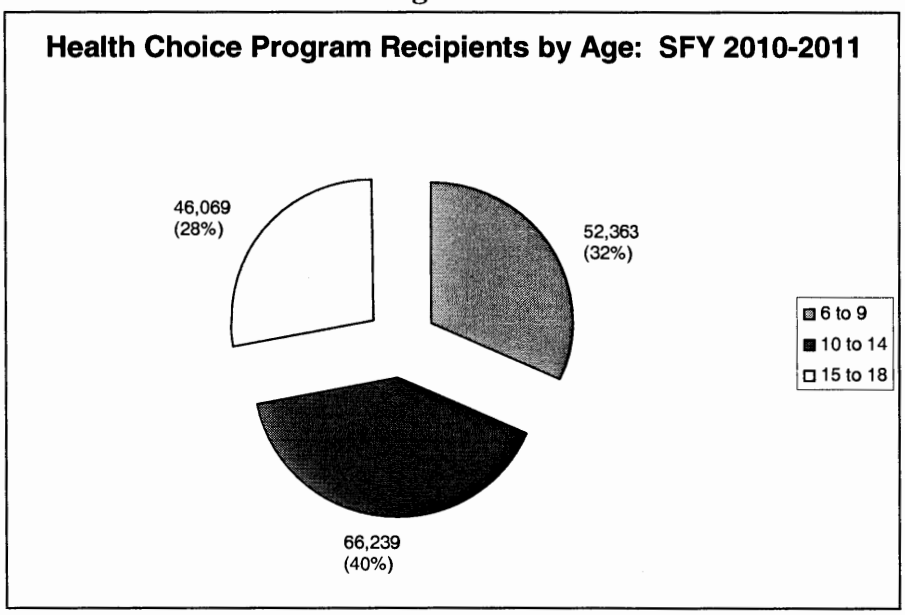
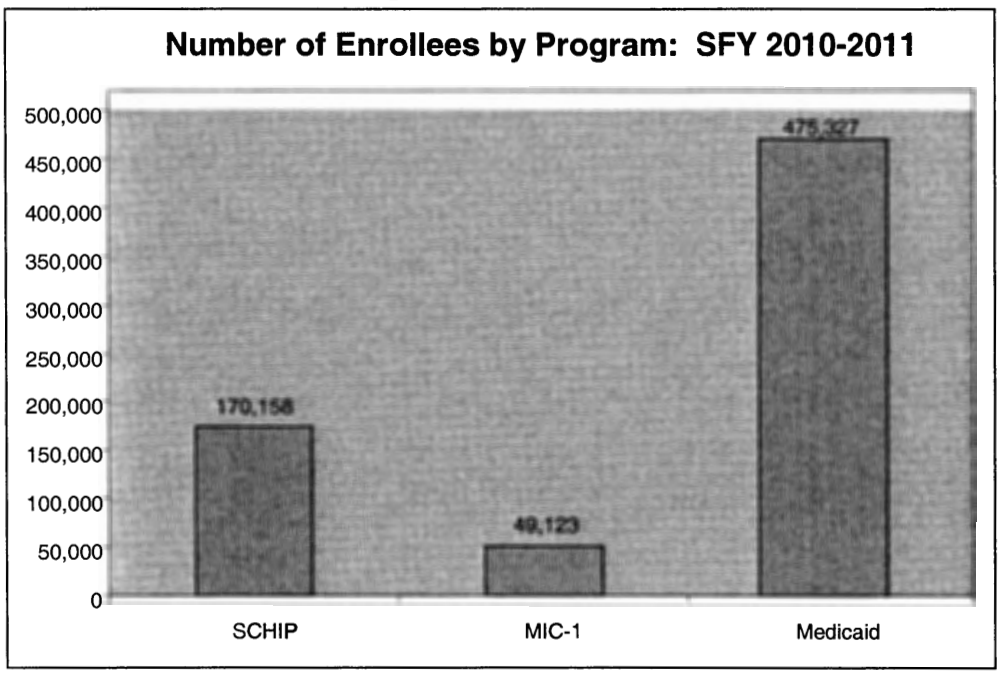


Figure 5 shows enrollment for the Health Choice Program, the Medicaid Expansion Group (MIC-1 in the Eligibility Information System), and the Medicaid Program (enrollees ages 6 – 18 only) for SFY 2010-2011. The ratio of low-income children ages 6 – 18 enrolled in the Medicaid Program compared to the Health Choice Program is greater than 2:1.

Figure 5.



Transition between the 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 recipient'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 recipient's household income increases to a point of making them ineligible for the Medicaid program, a family can apply for Health Choice eligibility in a higher income bracket.

In SFY 2011, the number of Medicaid recipients who transitioned to the Health Choice Program was 35,862. The number of Health Choice recipients who transitioned to the Medicaid Program was 45,252. This trend indicates that more recipients lived in households with declining versus increasing incomes.

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. 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 in collaboration with a host of state, regional, and local public, and private partners. DPH contracts with the NC Healthy Start Foundation (NCHSF), a private not-for-profit, for its public health program outreach and materials development expertise. NCHSF 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. In collaboration with the DPH minority outreach consultant, the Foundation has developed a double-sided flier to education potential recipients about Health Choice / Health Check (Medicaid EPSDT) Fact Sheet translated in 12 languages: 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.

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. State and local partners engaged in child health insurance outreach include:

Early Childhood Organizations: Smart Start, More-at-Four, Head Start, 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 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/Reduced Price School Meals). Other related collaborators include the School Nurses Association of North Carolina; the School Health Advisory Councils; the 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 (faculty and students). 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. To date, school systems in 48 of the State's 100 counties have conducted outreach efforts in elementary 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 and Nurse Practitioners; 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 & 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 Department 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; Homeless Shelters; Food Banks; Advocacy Groups; Communities in Schools; Legal Services; Libraries; Faith-Based Organizations, and the Salvation Army.

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; 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 outreach efforts. The Health Choice Program contracts with the NC Health Start Foundation, a private non-profit organization, to develop and disseminate promotional materials via various forms of media.

Income Level

The Federal Poverty Level (FPL) is adjusted every year in April. The income limits in **Table 3** were effective in January of 2011.

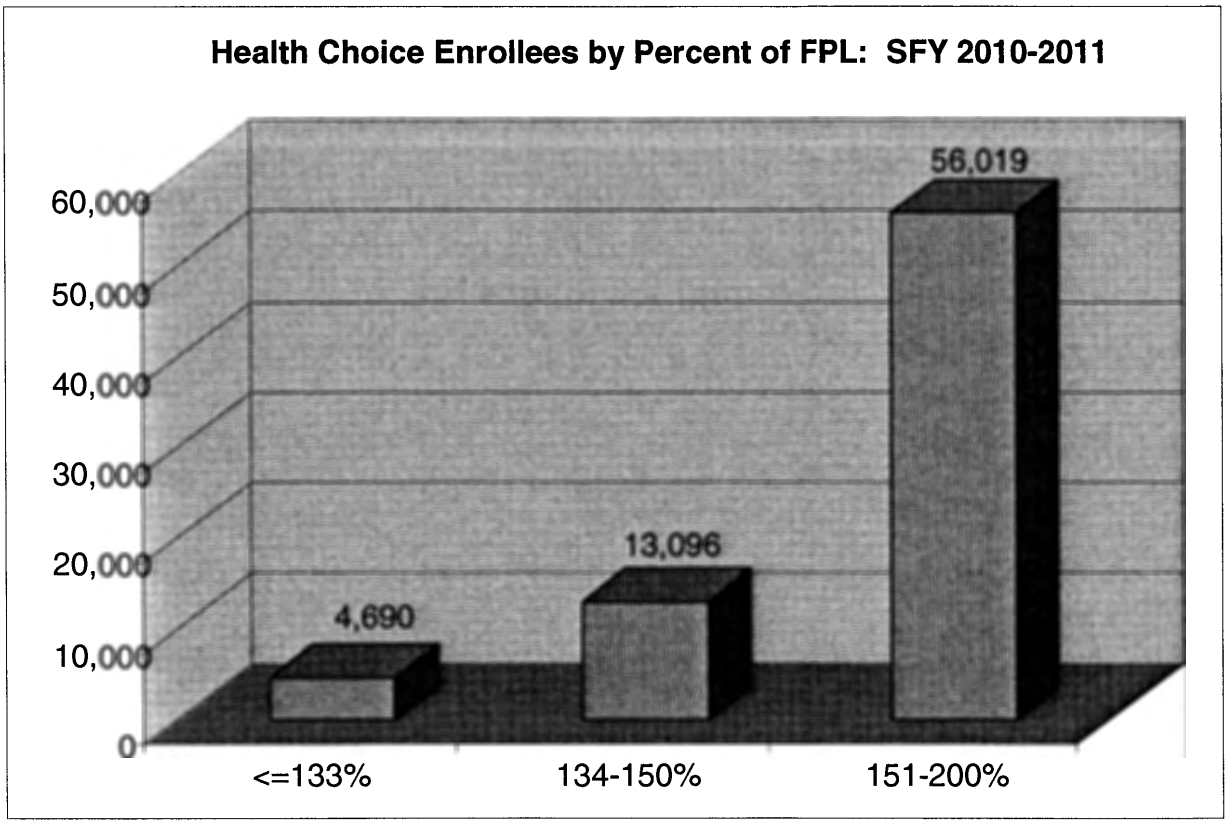
Table 3.

2011 Federal HHS Poverty Guidelines			
Persons in Family	**48 Contiguous States and D.C.**	**Alaska**	**Hawaii**
1	$10,890	$13,600	$12,540
2	14,710	18,380	16,930
3	18,530	23,160	21,320
4	22,350	27,940	25,710
5	26,170	32,720	30,100
6	29,990	37,500	34,490
7	33,810	42,280	38,880
8	37,630	47,060	43,270

SOURCE: *Federal Register*, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638.

To qualify for the Health Choice Program, a family's income cannot exceed 200 percent of the FPL. **Figure 6** shows that more than 75% of the children had family incomes between 151 percent and 200 percent of the FPL. Nearly 25% of the applicants had family incomes at or below 150 percent of the FPL.

Figure 6.



- Health Choice recipients living in families with income at or below 150% of the FPL are exempt from paying the enrollment fee of $50 per child, or $100 maximum for 2 or more children.

- Other cost sharing distinctions between recipients living at or below 150 percent of the FPL and recipients living at 151- 200 percent of the FPL are presented in **Table 4**.

- The Division of Medical Assistance is authorized to impose cost sharing in federal Title XXI regulations and G.S. 108A-70.21(d).

Table 4: Health Choice Eligibility Groups and Cost Sharing

Class	Group	Cost-Sharing
MIC-A	Income is 150% or less of the poverty income level and are members of a federally Recognized Native American Tribe or Alaskan Native.	• No enrollment fee • No prescription copayments • No copayments for office visits

MIC-J	Income of 150% or less of the Federal Poverty Income Level.	• No enrollment fee
		  • Generic Prescription copay: $1
		  • Brand Prescription when no generic available copay: $1
		  • Brand prescription when generic available copay: $3
		  • Over-the-counter copay: $1
		• No copayments for office visits
		• $10 non-emergency, emergency room visits

MIC-K	Income in excess of 150% up to 200% of the Federal Poverty Income Level.	• Enrollment fee: $50 per child or $100 maximum for two or more.
		  • Generic Prescription copay: $1
		  • Brand Prescription when no generic available copay: $1
		  • Brand prescription when generic available copay: $10
		  • Over-the-counter copay: $1
		• $5 copayments for office visits
		• $25 non-emergency, emergency room visits

MIC-L	Optional extended coverage. Income in excess of 200% up to 225% of the poverty income level.
	This group pays monthly premiums.
		• No enrollment fee
		  • Generic Prescription copay: $1
		  • Brand Prescription when no generic available copay: $1
		  • Brand prescription when generic available copay: $10
		  • Over-the-counter copay: $1
		• $5 copayments for office visits
		• $25 non-emergency, emergency room visits

MIC-1	Medicaid Expansion Groups: 1. Children 0 – 12 months of age with family income between 186% and 200% of the federal poverty income level; and 2. Children 13 months – 5 years of age with family income between 134% and 200% of the federal poverty income level.	Although this program is funded via Title XXI (State Children's Health Insurance Program) federal dollars and State appropriated funding, children enrolled in the Medicaid Expansion Group receive the same benefits as other children enrolled in Medicaid. NC Medicaid recipients under age 21 are exempt from co-payments.
MIC-S	Income in excess of 150% up to 200% of the poverty income level and are members of a Federally Recognized Native American Tribe or Alaskan Native.	• No enrollment fee • No prescription copayments • No copayments for office visits

The copayment structure in **Table 4** reflects cost sharing amounts in G.S. 108A-70.21(d) as of October 1, 2011. 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 recipients subject to co-payments to 5% of the family's income. Pursuant to 42 C.F.R. § 457.505(d)(1), all recipients 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 recipient's health insurance card.

OTHER HEALTH CHOICE AND MEDICAID DATA

The following tables illustrate additional trends in these health insurance programs.

Table 5: Total Number of Applications in SFY 2011

Health Choice (Title XXI) (ages 6–18)	Medicaid (Title XIX) (ages 6-18)	Medicaid Expansion (Title XXI) (ages 0–5)	Total
82,525	94,027	14,841	191,393

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
336,705	428,993	45,196	810,894

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

Table 7: Total Number of Children Enrolled in SFY 2011

Health Choice (Title XXI) (ages 6–18)	Medicaid (Title XIX) (ages 6-18)	Medicaid Expansion (Title XXI) (ages 0–5)	Total
170,158	475,327	49,123	694,608

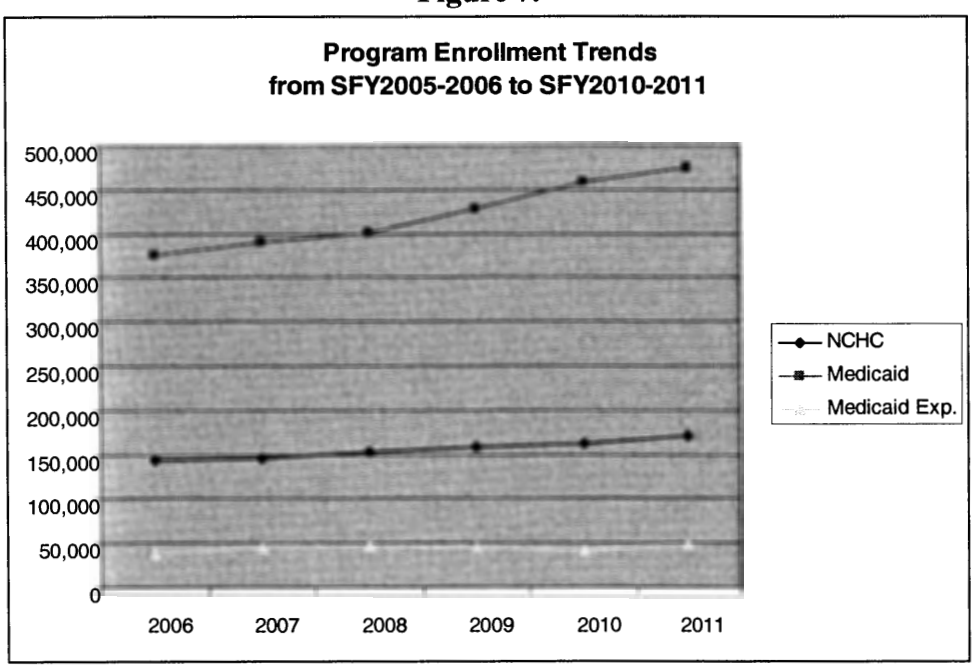
Table 8: Total Number of Children Enrolled to date*

State Fiscal Year	Health Choice (Title XXI) (ages 6–18)	Medicaid (Title XIX) (ages 6–18)	Medicaid Expansion (Title XXI) (ages 0–5)
2006	144,208	375,755	36,885
2007	146,178	390,210	44,522
2008	152,709	400,226	47,358
2009	158,679	427,573	45,744
2010	161,773	458,105	42,091
2011	170,158	475,327	49,123
Total	**933,705**	**2,527,196**	**265,723**

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

From 2006 to 2011, Health Choice enrollment grew by 18 percent whereas, Medicaid enrollment for children ages 6 through 18 grew by 26 percent. Health Choice enrollment has increased each consecutive year. The largest increase in enrollment occurred from SFY 2009-10 to SFY 2010-11. Medicaid Expansion enrollment actually decreased from SFY 2007-08 to SFY 2009-10, but increased by more than 7,000 recipients from SFY 2009-10 to SFY 2010-11. Conversely, enrollment of children ages 6 – 18 in Medicaid increased the most by approximately 30,000 recipients per year during that period. **Figure 7** below illustrates the enrollment growth trends in the three programs administered under the Division of Medical Assistance.

Figure 7.



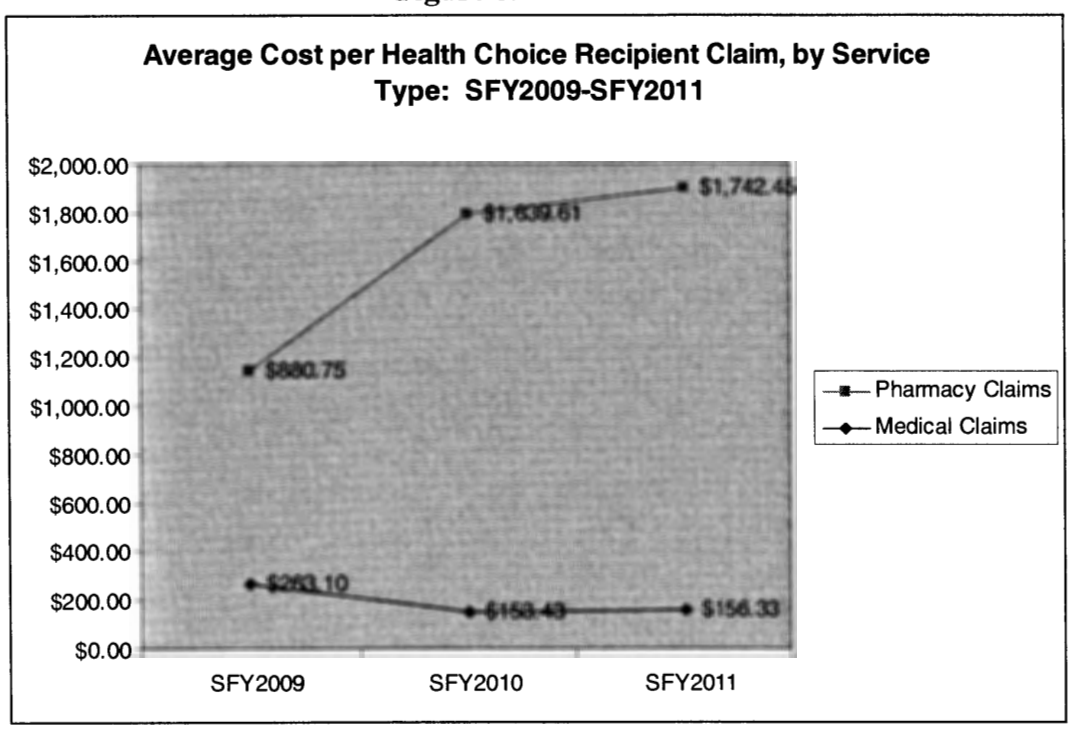
TRENDS IN HEALTH CARE UTILIZATION

Medical and Pharmacy Claims

Just as the cost of many goods and services within the U.S. economy have increased significantly in recent years, health care is no exception. **Figure 8** shows that the average cost per Health Choice recipient claim for pharmacy services more than doubled from $880 to $1,742 from SFY 2009 to SFY 2011. This trend may be attributable to inflation and increased drug manufacturing costs. Conversely, the average cost per NC Health Choice recipient *medical* service claim decreased by more than $100 from SFY 2009 to SFY 2011. Based on Blue Cross and Blue Shield reports regarding health service utilization and expenditures within the Health Choice program, one possible explanation is a decrease in emergency room use since emergency room services incur a higher cost than primary care and specialist visits. Health Choice program outreach efforts include education about the appropriate utilization of primary care versus emergency services.

In future fiscal years, a downward trend should continue for medical services costs and should begin for pharmacy costs. Although the Division of Medical Assistance was already reimbursing Health Choice providers at 100 percent of the Medicaid rate, the structuring of Health Choice benefits to be Medicaid-equivalent should decrease the cost of coverage. Individual services within the medical benefits package may be more restricted via utilization review and prior approval requirements and subsequently less costly for the State. Furthermore, a shared preferred drug list will eliminate certain drugs that were covered prior to Session Law 2011-145.

Figure 8.



Even though the cost per claim for medical services decreased from SFY 2009 to SFY 2011, the number of medical service claims per Health Choice recipient almost doubled over the same time span. However, the number of claims did decrease slightly from SFY 2010 to SFY 2011.

Figure 9 shows the trends in both pharmacy and medical services utilization among Health Choice recipients. The trend in medical and pharmacy service utilization is a concern from a State budget perspective as well as that of the well-being of recipients. It will be important to continue to monitor this trend and assess recipient health outcomes and the appropriate utilization of preventive care among recipients. 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. Health Choice recipients are now provided mandatory linkage to a primary care provider and a medical home under the Community Care of North Carolina managed care network. The State expects to see a decrease in the number of medical services claims in subsequent State Fiscal Years.

Figure 9.

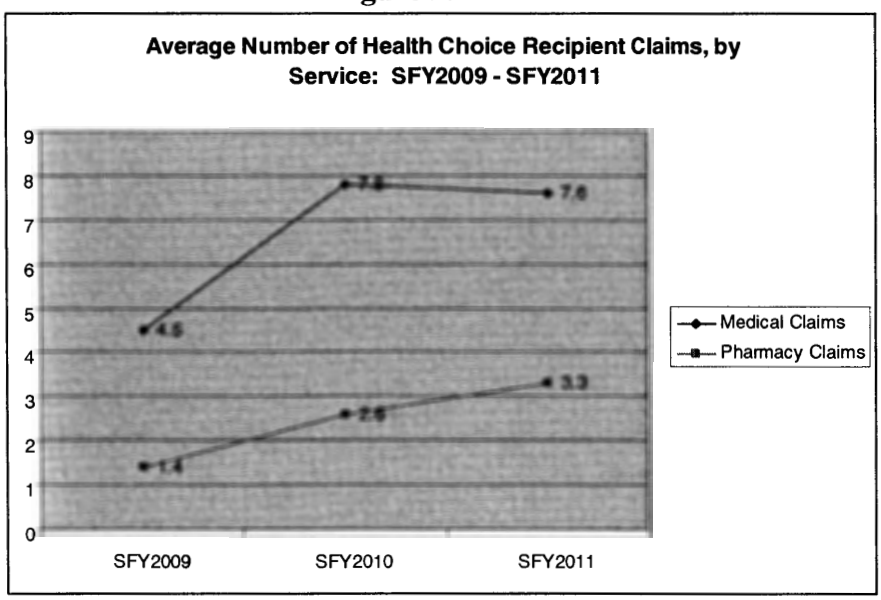


Figure 10 shows the trend in the number of Health Choice recipient claims for both medical and pharmacy services over the past three State Fiscal Years. Utilization is relative to the number of recipients enrolled. As Table 8 in this report shows, the number of Health Choice recipients ages 6 through 18 enrolled was 158,679 in 2009; 161,773 in 2010; and 170,158 in 2011. Therefore, as enrollment numbers increased, one would have anticipated an increase in the total number of recipient claims. However, enrollment only increased by 2 percent from SFY 2009 to SFY 2010, yet the number of medical services claims increased by 45 percent. The number of pharmacy claims decreased by 42 percent from SFY 2009 to SFY 2010, and remained constant from SFY 2010 to SFY 2011.

Figure 10.

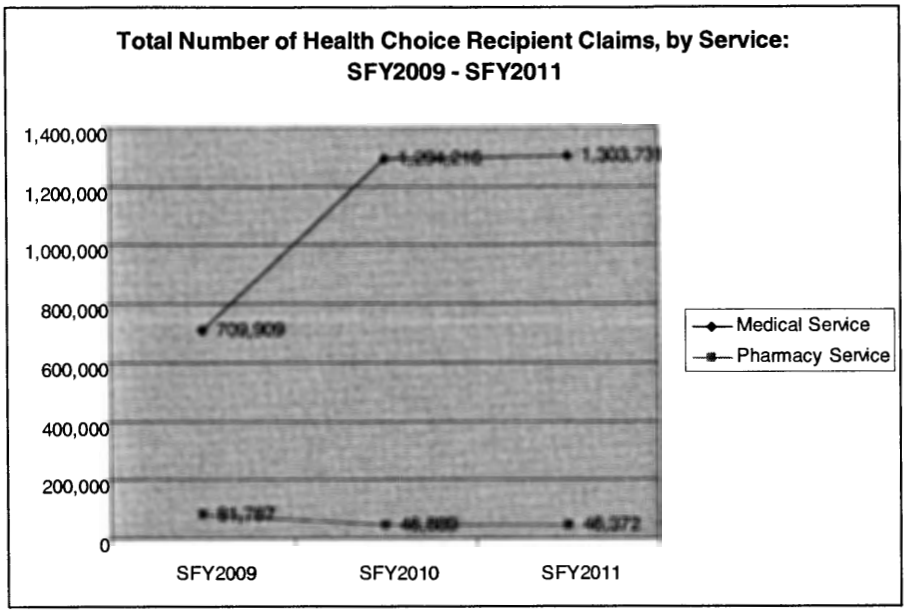
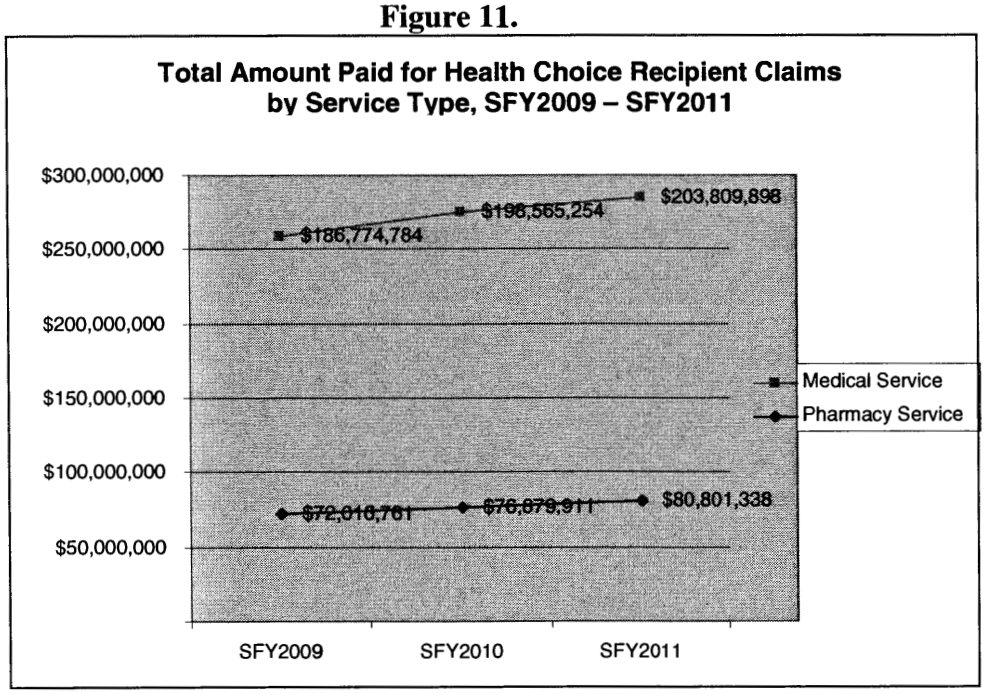


Figure 11 shows the trend in the total amount paid for Health Choice recipient claims for both medical and pharmacy services. The State paid 8 percent more for all medical services claims in SFY 2011 compared to SFY 2009. The State paid 11 percent more for all pharmacy services claims in SFY 2011 compared to SFY 2009. Increased enrollment paired with the inflationary cost of health care and pharmaceuticals were the most likely contributing factors to the trend.

Figure 11.



Vaccination Claims

Health Choice covers well-child visits and 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 43 percent increase in the total number of vaccine administration claims for Health Choice recipients from SFY 2009 to SFY 2011. Health Choice enrollment increased for each of 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 recipients. Successful outreach and recipient 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 recipients from SFY 2009 to SFY 2011. The number of vaccine claims increased by 44 percent from SFY 2009 to SFY 2011. 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.

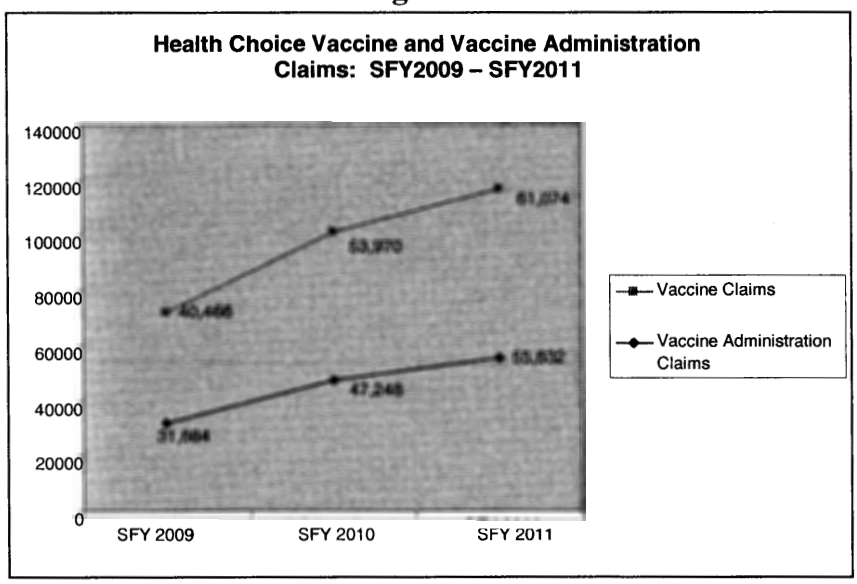


Figure 13 shows the trend in the program cost for vaccine administration to Health Choice recipients from SFY 2009 to SFY 2011. The total cost per year increased by 27 percent over 3 years. In subsequent fiscal years, the State should see a decrease in the amount reimbursed to Health Choice providers for vaccine administration. As a result of the transition to Medicaid-equivalent coverage for Health Choice recipients, 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.

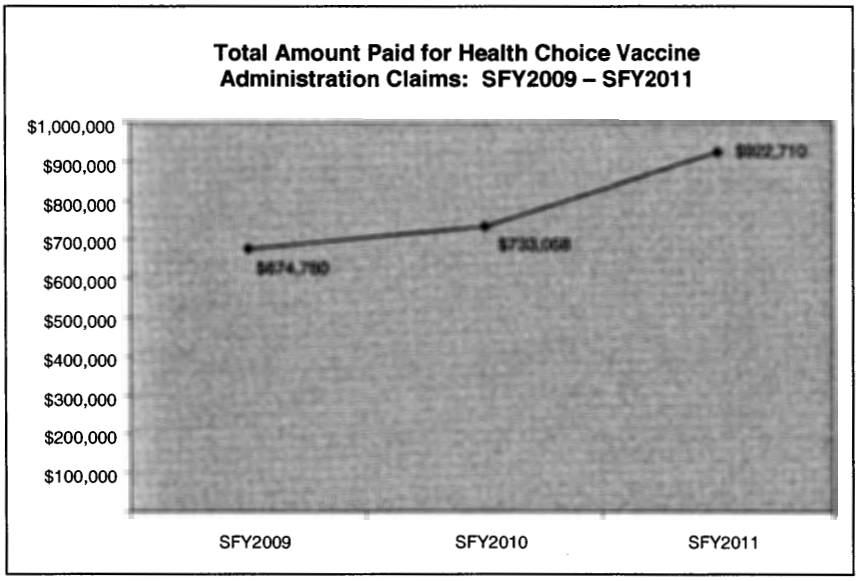


Figure 14 shows a trend of a 12 percent decrease in the total amount paid for vaccine claims from SFY 2009 to SFY 2010, and a subsequent 29 percent increase in the total amount paid for vaccine claims from SFY 2010 to SFY 2011.

Figure 14.

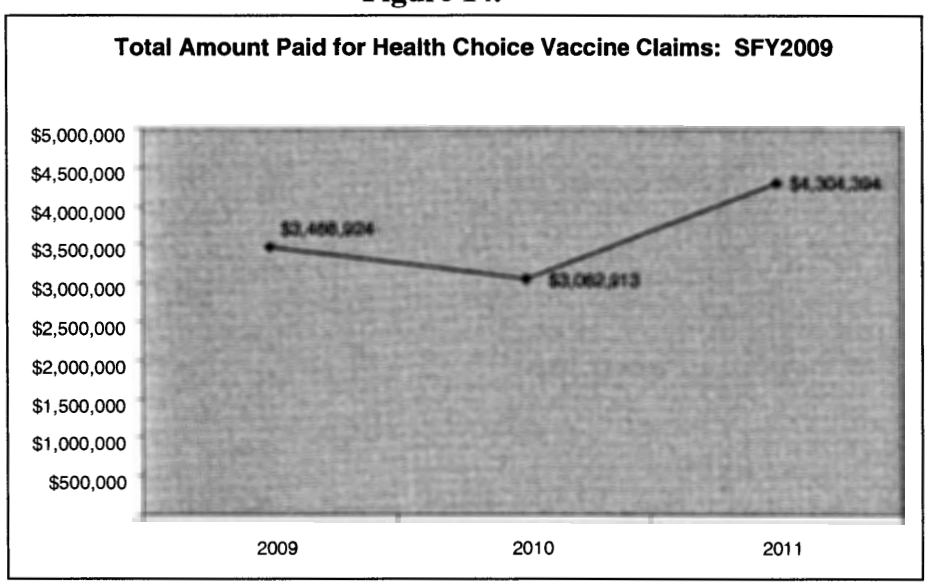
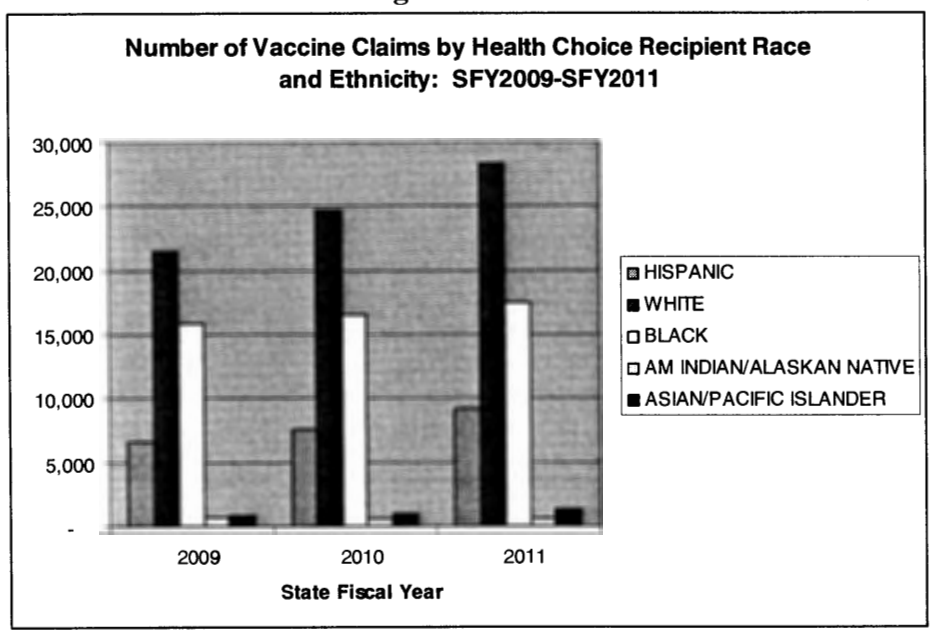


Figure 15 shows the number of vaccine claims by Health Choice recipient race and ethnicity. From SFY 2009 to SFY 2011, the number of claims increased by: 24 percent among White recipients; 10 percent among Black recipients; 29 percent among Hispanic recipients; and 31 percent among Asian recipients. The number of claims decreased by 10 percent among American Indian / Alaska Native populations. There were 665 vaccine claims for 508 recipients in SFY 2009 and 596 vaccine claims for 511 recipients in SFY 2011. The American Academy of Pediatrics Advisory Committee on Immunization Practices Schedule of Vaccinations recommends more vaccines for children ages 11 – 12 years than for children ages 13 - 18. It is possible that a cohort of children re-enrolled in consecutive years from 2009 - 2011 and as they aged, they needed fewer vaccines. The Division of Medical Assistance will continue to monitor this trend and any potential need for targeted outreach and education regarding age-appropriate immunizations.

Figure 15.



LEGISLATIVE CHANGES TO THE PROGRAM IN 2010 AND 2011

The State took steps in the 2010 legislative session to transfer the administration of Health Choice from the State 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 Employees 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. North Carolina Session Law 2011-145 became law in June 2011. It states that, "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 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, SL 2011-145 repealed G.S. 108A-70.23. *Services for children with special needs established; definition; eligibility; services; limitation; recommendations; no entitlement.* Because the statute was repealed, the previous screening and identification process for services for Health Choice recipients with special health care needs is no longer necessary. Health Choice Providers will now obtain prior approval for medically necessary services for Health Choice recipients with special health care needs the same way that they do for Medicaid recipients.

Effective July 25, 2011, Session Law 2011-399 mandated standardized requirements for the oversight of Medicaid and Health Choice provider applications, screenings, enrollment, and auditing. All NC Health Choice providers must now become Medicaid-enrolled providers. This involves signing a Medicaid Provider Agreement, paying a $100 enrollment fee (and renewing every three years), and completing (or having a representative complete) NC Department of Health and Human Services trainings. Division of Medical Assistance oversight of providers for both Medicaid and Health Choice program recipients will streamline program administration.

As of October 1, 2011, all Health Choice recipients must be linked to a primary care provider medical home. Providers enrolled in the Community Care of North Carolina (CCNC) managed care network receive both a per member, per month reimbursement of $6.12 per recipient and fee-for-service reimbursement from the State. These system linkages of recipients to providers should improve access to care, the efficiency of health services utilization and coordination, and the ultimate quality of care for program recipients.

ANALYSIS OF TRENDS AND PROJECTIONS FOR CONTINUED PROGRAM FUNDING

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 funding of State Children's Health Insurance Programs through 2015. The ACA also requires a maintenance of coverage for children through 2019.

Effective January 1, 2014, Medicaid eligibility will expand to include low income children living in families with incomes below 133 percent of the FPL with a 5 percent disregard. In SFY 2010-2011, approximately 6 percent of Health Choice recipients ages 6 through 18 were living in families with incomes below 133 percent of the FPL. More than 75 percent of Health Choice recipients ages 6 through 18 were living in families with incomes of 151 – 200 percent of the FPL. Therefore, in 2014, the impact of the Medicaid eligibility expansion may not yield a significant transition of recipients ages 6 – 18 from Health Choice to Medicaid. However, the Federal Medical Assistance Percentage (FMAP) is higher for Title XXI programs than for Title XIX (Medicaid) Programs. Under the expanded Medicaid enrollment for children living in families with income below 133% of the FPL, states will be able to claim the enhanced FMAP rate for children previously enrolled in a Title XXI program (NCHC) who shift to Medicaid eligibility. Furthermore, the ACA authorizes a 25 percent increase in the Title XXI Program enhanced FMAP beginning in October of 2015.

Title XXI dollars also pay for children ages 0 – 5 enrolled in the North Carolina Medicaid Expansion program. North Carolina therefore receives the higher, Title XXI Program FMAP for these recipients. Medicaid Expansion recipients are in families with incomes of 186 percent – 200 percent of FPL for ages 0 to 12 months, and 134 percent – 200 percent for ages 13 months to 5 years. In SFY 2010-11, 49,123 children were enrolled in North Carolina's Medicaid Expansion program.

Effective October 1, 2011, both the Health Choice and Medicaid Programs began using the same claims processing vendor, HP Enterprise Services. This consolidation of claims processing under one vendor will provide a standardized and efficient means of managing health services claims for the programs administered by the Division of Medical Assistance.

RESOURCES

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

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

- *Basic Medicaid and NC Health Choice Billing Guide.*
  See: http://www.ncdhhs.gov/dma/basicmed

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

- For legislative summaries and policy analysis regarding the Patient Protection and Affordable Care Act provisions relevant to State Title XXI programs, see:
  http://www.medicaid.gov/AffordableCareAct/Provisions/Childrens-Health-Insurance-Program.html.