North Carolina CARTS FY2022 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

North Carolina

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

North Carolina Health Choice Program

Who should we contact if we have any questions about your report?

4. Contact name:

Amanda Tromblee

5. Job title:

CHIP Program Manager

6. Email:

amanda.tromblee@dhhs.nc.gov

7. Full mailing address:

Include city, state, and zip code.

2501 Mail Service Center, Raleigh, NC 27699

8. Phone number:

9192192803

PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather all data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☑ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Managed Care, FFS and PCCME delivery systems are available to CHIP beneficiaries. The delivery system is determined by the child's health care needs. Children who are enrolled in FFS have a higher level of health care needs.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- (●) Yes

  1a. How much is your enrollment fee?

  $ 50

- ( ) No

2. Does your program charge premiums?

- (●) Yes

  2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

  - (●) Yes
  - ( ) No

  2b. Indicate the range of premiums and corresponding FPL ranges for one child.

  ## Premiums for one child, tiered by FPL

FPL starts at		FPL ends at
133	→	211

Premium starts at		Premium ends at
$	→	$

- ( ) No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ◉ No

3b. What's the maximum premium fee a family would be charged each year?

$

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

N/A

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☑ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Managed Care, FFS and PCCME delivery systems are available to CHIP beneficiaries. The delivery system is determined by the child's health care needs. Children who are enrolled in FFS have a higher level of health care needs.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- (●) Yes
- ( ) No
- ( ) N/A

2. Have you made any changes to the eligibility redetermination process?

- (●) Yes
- ( ) No
- ( ) N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ( ) Yes
- (●) No
- ( ) N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- (●) Yes
- ( ) No
- ( ) N/A

5. Have you made any changes to the single streamlined application?

- ( ) Yes
- (●) No
- ( ) N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ( ) Yes
- (●) No
- ( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

SPA # 18-007-Implemented provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor declared or federally declared disaster areas in North Carolina. In the event of a natural disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ◉ Yes
- ○ No
- ○ N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- (●) Yes
- ( ) No
- ( ) N/A

2. Have you made any changes to the eligibility redetermination process?

- (●) Yes
- ( ) No
- ( ) N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ( ) Yes
- (●) No
- ( ) N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- (●) Yes
- ( ) No
- ( ) N/A

5. Have you made any changes to the single streamlined application?

- ( ) Yes
- (●) No
- ( ) N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ( ) Yes
- (●) No
- ( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to coverage for your CHIP pregnant individuals eligibility group?
For example: expanding eligibility or changing this population's benefit package.

- (●) Yes
- ( ) No
- ( ) N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ( ) Yes
- (●) No
- ( ) N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ( ) Yes
- (●) No
- ( ) N/A

19. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

SPA # 18-007: Implemented provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor declared or federally declared disaster areas in North Carolina. In the event of a natural disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas. SPA #22-0014- Provided extended postpartum coverage to all CHIP beneficiaries. Continuous eligibility went from 60 days to 12 months of continuous eligibility for CHIP beneficiaries who become pregnant.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ◉ Yes
- ○ No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7:

"Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2021	Number of children enrolled in FFY 2022	Percent change
Medicaid Expansion CHIP	208,973	233,982	11.968%
Separate CHIP	96,673	68,499	-29.144%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

As to the decrease in CHIP enrollment, the State reviewed changes in CHIP Enrollment as a result of the COVID-19 Public Health Emergency. First, this population is sensitive to changes in the unemployment rate. Typically, as unemployment decreases our CHIP program population increases and, when there are increases in unemployment our CHIP population decreases. There was a surge in unemployment during this time as a result of COVID-19 and, it is highly likely that this impacted our CHIP population. Typically, when this occurs they do not disenroll completely but rather become eligible for Medicaid (and are enrolled). Furthermore, as a direct result of the PHE (and under the guidance of CMS) changes have been made to the way the State of North Carolina determines eligibility for Medicaid and CHIP. For the duration of the Public Health Emergency, when a recipient's eligibility period concludes, they are no longer allowed to have their benefits terminated (with a few exceptions which I will list*) or transfer to another coverage group where they will receive lesser benefits. Therefore, a beneficiary who would ordinarily move from Medicaid to CHIP would be prevented from doing so by these measures and, they would remain in Medicaid. *The only way a member may lose eligibility would be: the death of the member, voluntarily asking to terminate benefits or, members moving their residence outside of North Carolina. In addition, as of June 2021, CHIP beneficiaries may lose eligibility if they are found to be ineligible (aging out of the program, etc.) at the end of their eligibility certification period when they re-determined.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the Census Bureau did not release standard one-year ACS estimates in 2020 and that row is intentionally left blank.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2013	Not Available	Not Available	Not Available	Not Available
2014	Not Available	Not Available	Not Available	Not Available
2015	70,000	6,000	3%	0.3%
2016	67,000	5,000	2.8%	0.2%
2017	66,000	7,000	2.8%	0.3%
2018	67,000	8,000	2.8%	0.3%
2019	69,000	7,000	2.9%	0.3%
2020	Not Available	Not Available	Not Available	Not Available
2021	63,000	7,000	2.6%	0.3%

Percent change between 2019 and 2021
-10.34%

1. What are some reasons why the number and/or percent of uninsured children has changed?

NC Medicaid has conducted outreach to assist uninsured residents with obtaining Medicaid coverage. This could also be a result of the COVID-19 public health emergency. There was a surge in unemployment during this time as a result of COVID-19 and, it is likely that people became eligible due to unemployment, and applied for Medicaid and CHIP coverage.

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ◉ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

N/A

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

◉ Yes

1a. What are you doing differently?

A new Minority Outreach Coordinator was hired in mid-December 2019 filling the vacancy created by previous staff's retirement. Her direct experience in local outreach for ACA enrollment, especially with Latino populations and rural community resource networks was an added asset for new collaborations and strategies. She also began networking with state and local service agencies, shadowing the CYSHCN Help Line coordinator regarding meetings and presentations to deepen her knowledge and expertise about NC's children's health insurance resources. By February, she was independently scheduling and attending targeted outreach events. The outreach team comprised of the Minority Outreach Coordinator, Help Line Coordinator and the CYSHCN Access to Care Specialist traditionally use a health equity lens to target outreach efforts in low resource geographic areas, in addition to marginalized, disenfranchised populations that would benefit from accessing NC's public health insurance options. The outreach team met monthly with the Best Practice Unit manager to discuss optimal outreach strategies, using state Medicaid enrollment data to target county populations for stakeholder engagement and outreach, and to develop updated outreach materials. A total of 107 outreach activities occurred in FFY 21-22. In order to continue outreach efforts during COVID19 quarantine and social distancing requirements, the Outreach staff developed revised strategies to continue promoting the value of NC Medicaid/Health Choice. Staff participated in more collaborative and consultative opportunities (ex. Stakeholder meetings to share and promote NC Medicaid/Health Choice information). Staff reached out to various stakeholder organizations or agencies to participate and present in their virtual community meetings. Group examples include: Burlington PEDS, Graham County, Greensboro CDSA, Brunswick County, Dorcas Ministries, Lincoln Community Health Center, Garner Advent Church, The Division of Child development and Early Education, Triangle Native Society, American Indian Mothers, Inc, Guilford Native American Society, Lionel Lee Center for Wellness, St. Gerard House, Arms Around ASD, and family Caregiver Support Program. During the pandemic travel curtailment, Outreach staff also prepared information packets which were mailed to sites with outreach materials,

promotional and Help Line flyers to community organizations for distribution.

○ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

◉ Yes

2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

North Carolina Medicaid is working to improve Health Equity outcomes. Many outreach efforts have been made to target minority populations, especially those who live in rural communities and areas, and have less access to medical care. Of NC children under age 19 with insurance coverage, 41% are covered via Medicaid/CHIP with 44% insured with other private/public insurance options, leaving an estimated 5.5% still uninsured https://kidshealthcarereport.ccf.georgetown.edu/states/north-carolina. However, this data does indicate that 11.9% of uninsured are Latino, which id down from 2019, and with 10.7% Tribal or Native American uninsured. Past outreach event experience shows these groups are more responsive to in-person, culturally relatable outreach experiences. Further in NC, these two populations are typically located in rural, low-resource communities, which includes sparce or no internet connectivity options, so outreach has been conducted to the Latino and Native American Community Organizations through collaborative approaches, and presentations.

○ No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

NC Medicaid has conducted outreach in many ways, by distributing literature to community organizations, schools, free clinics, and community health care organizations such as Duke. 21.5% of the outreach activities were conducted via a virtual or electronic platform (email, phone, virtual meeting) as a result of the COVID19 public health emergency. However, in 2021, more opportunities to interact with the community in person were available, with safe distancing applied, and 40% of outreach related efforts were conducted in person.

4. Is there anything else you'd like to add about your outreach efforts?

The CYSHCN Help Line serves as a statewide resource to assist families in identifying applicable information and services for their child with special needs, especially in their community. Help Line callers consistently report Medicaid/NC Health Choice as their primary insurance source. Callers can request resources to access community supports, medical or health care services applicable to their child's reported needs. One hundred percent (100%) of responding callers report the helpfulness and how well their questions were addressed. Further, 100% of callers reported they would use the Help Line again or refer others for use. Outreach staff, in cooperation with the NC Pediatric Society, continue to facilitate the quarterly NC Coalition to Promote Children's Health Insurance. The Coalition continues as a forum for statewide stakeholders to address topics that can directly impact marginalized or vulnerable populations who would most benefit from enrollment and services available via NC Medicaid and Health Choice. Regular attendees represent: NC Division of Public Health Children and Youth Branch, Fostering NC project via the NC Pediatric Society, Office of Rural Health, Office on Refugee Health, NC Association of Community Health Centers, and NC Child. Coalition meeting topics have included: updates on NC's Medicaid managed care transformation, strategies to support community census participation in under-represented populations, and health inequity/access to essential health care resources in disenfranchised populations especially during the COVID pandemic.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Browse...

Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

%

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting these data?

N/A

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

- (●) Yes

  1a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?

  0 %

  1b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?

  %

- ( ) No
- ( ) N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- ( ) Yes
- (●) No

3. Do you send renewal reminder notices to families?

- ○ Yes
- ◉ No

4. What else have you done to simplify the eligibility renewal process for families?

NC has implemented automatic straight through processing of renewals. If the system can redetermine the individual eligible for the same level or greater benefit, the system processes the case and sends the notice without any caseworker intervention. If it cannot, the case falls out of straight through and the local agency completes the processing.

5. Which retention strategies have you found to be most effective?

The MAGI 90 day reopen. If the individual provides the information within 90 days of case closure, the case is reopened without requiring a new application.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

N/A

7. Is there anything else you'd like to add that wasn't already covered?

N/A

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2022?
Don't include applicants being considered for redetermination - these data will be collected in Part 3.

1232

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

703

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

518

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

4. How many applicants were denied CHIP coverage for other reasons?

11

5. Did you have any limitations in collecting these data?

N/A

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	57.06%
Denied for eligibility reasons	42.05%
Denials for other reasons	0.89%

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2022?

38079

2. Of the eligible children, how many were then screened for redetermination?

38079

3. How many children were retained in CHIP after redetermination?

36855

4. How many children were disenrolled in CHIP after the redetermination process? This number should be equal to the total of 4a, 4b, and 4c below.

1224

4a. How many children were disenrolled for procedural reasons? This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

311

4b. How many children were disenrolled for eligibility reasons? This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

561

4c. How many children were disenrolled for other reasons?

352

5. Did you have any limitations in collecting these data?

N/A

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	96.79%
Children disenrolled after redetermination	3.21%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	25.41%
Children disenrolled for eligibility reasons	45.83%
Children disenrolled for other reasons	28.76%

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year

changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2022?

382876

2. Of the eligible children, how many were then screened for redetermination?

382876

3. How many children were retained in Medicaid after redetermination?

382383

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

493

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

46

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

304

4c. How many children were disenrolled for other reasons?

143

5. Did you have any limitations in collecting these data?

N/A

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	99.87%
Children disenrolled after redetermination	0.13%

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	9.33%
Children disenrolled for eligibility reasons	61.66%
Children disenrolled for other reasons	29.01%

Part 5: Tracking a CHIP cohort over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2022) and six months later (July - Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2023) and 18 months later (July - Sept 2023). If data are unknown or unavailable, leave it blank - don't enter a zero unless these data are known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP in December 2021.

○ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
99	6066	7419	3151

July - September 2022 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
96	5678	6919	2972

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	14	12	<11

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	12	12	<11

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	374	488	175

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	291	365	119

9. Is there anything else you'd like to add about your data?

N/A

January - March 2023 (12 months later): to be completed next year
Next year you'll report data about your cohort for this section.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

N/A

Part 6: Tracking a Medicaid Cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2022) and six months later (July-Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2023) and 18 months later (July-Sept 2023). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in Medicaid in December 2021.

○ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
18454	7318	11326	5651

July - September 2022 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later? Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
18091	6864	10749	5338

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
11	13	11	<11

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	<11	<11	<11

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
352	441	566	306

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
83	235	356	206

9. Is there anything else you'd like to add about your data?

N/A

January - March 2023 (12 months later): to be completed next year
Next year, you'll report data about your cohort for this section.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in Medicaid 18 months later?
Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

N/A

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- ○ Yes
- ◉ No

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and

parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- ○ Yes
- ◉ No

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- ◉ Yes
- ○ No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- ◉ Yes
- ○ No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

In accordance with 45 CFR 455 and 457, North Carolina has various safeguards to prevent, investigate, and refer cases of Medicaid fraud, waste, and abuse. Written processes are in place to conduct investigations, provider self-audits, recoupments, and referral of credible allegations of fraud to law enforcement. The state uses automated prepayment edits and audits in the MMIS system; robust data analytics to detect aberrant billing patterns; mechanisms for reporting fraud, waste, and abuse electronically and telephonically; prepayment claims review; and targeted post-payment audits.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

- (●) Yes

  5a. What safeguards and procedures do the Managed Care plans have in place?

  The NC Medicaid Managed Care Plans are contractually required to have written plans incorporating methods and procedures for prevention, investigation, and referral of cases for fraud and abuse. CHIP beneficiaries are not included in managed care plans.

- ( ) No

- ( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2022?

<11

7. How many cases have been found in favor of the beneficiary in FFY 2022?

<11

8. How many cases related to provider credentialing were investigated in FFY 2022?

20

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2022?

6

10. How many cases related to provider billing were investigated in FFY 2022?

477

11. How many cases were referred to appropriate law enforcement officials in FFY 2022?

59

12. How many cases related to beneficiary eligibility were investigated in FFY 2022?

1587

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2022?

<11

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- ○ Yes
- ◉ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

- ○ Yes
- ◉ No

17. Is there anything else you'd like to add that wasn't already covered?

The Division of Health Benefits has oversight responsibilities for six (6) Behavioral Health Managed Care Organizations, as well as five (5) prepaid health plans. One of the oversight tools utilized for compliance are operational reports submitted on a regular cadence by the managed care entities.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5' group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	<11	11	24971	49518	36322

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	0	<11	16227	31407	19855

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	0	<11	15805	30362	18168

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2022?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	0	<11	7834	12787	9367

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2022?

69

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

N/A

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2022 CARTS report, the only option for reporting CAHPS results will be through the submission of raw data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database.

1. Did you collect the CAHPS survey?

- (●) Yes

  1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database? Please note this is a requirement for FFY 2022.

  - ( ) Yes
  - (●) No

- ( ) No

Part 2: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of the total computable amount of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act, 42 CFR 457.10 and 457.618.] States may only claim HSI expenditures after funding other costs to administer their CHIP State Plan.

1. Does your state operate Health Services Initiatives using CHIP (Title XXI) funds? Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

North Carolina CHIP Health Services Initiative (HSI) to Promote Early Literacy as Part of Pediatric Primary Care

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Reach Out and Read seeks to serve all children 0-5 years old eligible for Medicaid in the State, prioritizing counties where Reach Out and Read penetration is low, and well-child visit compliance is also low.

4. How many children do you estimate are being served by the HSI program?

232000

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Reach Out and Read utilizes a combination of outputs data (number of ROR clinical locations, number of providers trained, children served, books provided), short-term outcomes data (from parent survey), and long-term outcomes data (from longitudinal research) to evaluate impact. Our ROR NC uses ongoing quality implementation tools to assess fidelity to the mode and works with ROR programs to evaluate implementation best practices. A close focus on provider training and engagement also allows for an accurate picture of model fidelity, ensuring that children in NC experience the outcomes present in our research. From our data on beneficiaries and practices participating in ROR, we measure impact by comparing immunizations, well-child visits, and depression screenings between participants and non-participants in the program.

7. What outcomes have you found when measuring the impact?

Reach Out and Read is a key strategy for pediatric clinicians to promote the positive, language-rich parent- and caregiver-child interactions that promote attachment, build bonds and help to provide the resilience needed to buffer the impact of Adverse Childhood Experiences (ACEs). The buffering effect of these loving relationships can create more resilient families and improve the health outcomes and well-being of children who face systemic barriers to their ability to thrive. The impacts of ACES on early childhood development lead to disparities in school readiness skills - both cognitive and behavioral - such that children growing up in poverty, in marginalized communities, and in disadvantaged neighborhoods are at greater risk for school problems and the consequent lower levels of achievement and wellbeing that have life-long impacts. Encouraging parents to read aloud together with their young children and create routines and special moments is a tool to combat inequity and address the social determinants of health. Supporting and enhancing healthy early relationships through books and reading aloud builds a foundation for the early childhood development necessary for school readiness. Outcomes for Quality Family Environments: Clinics see improved relationships with patients Participating clinics report improved clinic culture and commitment to local communities. Participants in the ROR program had higher immunization and well-child visit rates than the overall NC Medicaid population.

8. Is there anything else you'd like to add about this HSI program?

The impacts of Reach Out and Read are well-evaluated and tested over time. The unprecedented experience of the pandemic, however, has further demonstrated the critical nature of resilience for children and the adults who care for them alongside the importance of the medical home as a touch point to support families. This HSI project is allowing for significant progress along the goal of scaling high-quality ROR for all Medicaid eligible children across North Carolina, starting at birth.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Objective: To reduce the number of uninsured children living in families with incomes below 200% of the federal poverty guidelines. Performance Goal: Increase the number of eligible applicants accepted into the NC Health Choice Program by 3%.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

4. Numerator (total number)

135000

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

The total number of children enrolled in CHIP in the last FFY

6. Denominator (total number)

302481

Computed: 44.63%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

North Carolina has made progress towards enrolling uninsured children in CHIP. The rate of uninsured children in North Carolina was higher for 2019, at 5.8% and has dropped to 5.5% for FFY 2022. NC Medicaid has also been working on Medicaid Expansion for Children, merging the SCHIP program with Medicaid, and raising the FPL for children in Medicaid to 211%.

10. What are you doing to continually make progress towards your goal?

North Carolina has made progress towards enrolling uninsured children in CHIP. NC Medicaid has also been working on Medicaid Expansion for Children, merging the SCHIP program with Medicaid, and raising the FPL for Medicaid to 211%.

11. Anything else you'd like to tell us about this goal?

N/A

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is your objective as listed in your CHIP State Plan?

Completing this objective is required.

To reduce the number of uninsured children living in families with incomes below 200% of the federal poverty guidelines.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

To identify and decrease disparities by race and ethnicity for the number of applications received relative to the total population of uninsured children by race and ethnicity.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Use U.S. Census and other available data to identify the number of uninsured children in the State living below 200% FPL, by race and ethnicity.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

Total number of uninsured children living in NC in 2022

6. Denominator (total number)

142000

Computed:

7. What is the date range of your data?

Start

mm/yyyy

09 / 2021

End

mm/yyyy

10 / 2022

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

North Carolina has made progress towards this goal in this FFY by conducting targeted outreach to community organizations and clinics, that interact with members of these identified races and ethnicities, in an effort to decrease disparity in health care among these populations. In NC, the number of Latin children who are uninsured, has decreased just over 2% since 2019, leaving the percentage of uninsured Latin children at 11.9% in NC as of 2022.

10. What are you doing to continually make progress towards your goal?

North Carolina will be continuing the progress made towards this goal in FFY by continuing to conduct targeted outreach to community organizations and clinics, that interact with members of these identified races and ethnicities, in an effort to decrease disparity in health care among these populations. North Carolina is also completing many Health Equity initiatives to help decrease disparities in underserved populations.

11. Anything else you'd like to tell us about this goal?

N/A

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Identify the number of uninsured children by county, living below 200% FPL, by race and ethnicity.

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Number of uninsured children by county, living under 200% FPL, by race and ethnicity Numerator would be dependent on the data from that county) anywhere from 0-19,300

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

Total number of uninsured children living in NC during 2022

6. Denominator (total number)

142000

Computed:

7. What is the date range of your data?

Start

mm/yyyy

09 / 2021

End

mm/yyyy

10 / 2022

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

North Carolina has made progress towards this goal in this FFY by conducting targeted outreach to community organizations and clinics, that interact with members of these identified races and ethnicities, in an effort to decrease disparity in health care among these populations. In NC, the number of Latin children who are uninsured, has decreased just over 2% since 2019, leaving the percentage of uninsured Latin children at 11.9% in NC as of 2022. North Carolina has also been conducting targeted outreach to rural areas in an effort to decrease health disparities and increase access to care in these communities.

10. What are you doing to continually make progress towards your goal?

North Carolina has made progress towards this goal in this FFY by conducting targeted outreach to community organizations and clinics, that interact with members of these identified races and ethnicities, in an effort to decrease disparity in health care among these populations. In NC, the number of Latin children who are uninsured, has decreased just over 2% since 2019, leaving the percentage of uninsured Latin children at 11.9% in NC as of 2022. The number of Asian/ Pacific Islander/ Native Hawaiian children who are uninsured, decrease din NC from 6% in 201 to 3.5% in 2021-2022. North Carolina has also been conducting targeted outreach to rural areas in an effort to decrease health disparities and increase access to care in these communities to also help decrease these disparities.

11. Anything else you'd like to tell us about this goal?

N/A

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Work with the subcontractor to provide supplemental outreach and education to the top 2 races with the identified disparity.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Number of uninsured children in NC by race

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

Total number of uninsured children in NC in 2022

6. Denominator (total number)

142000

Computed:

7. What is the date range of your data?

Start

mm/yyyy

09 / 2021

End

mm/yyyy

10 / 2022

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

While North Carolina did conduct targeted outreach to many different organizations who worked with people of many different races and ethnicities, there is a much larger disparity for American Indian/ Alaska Native children, and Black/ African American populations. North Carolina has still continued to conduct targeted outreach to these communities, and has also continued work with the goal of increasing Health Equity for all North Carolinians. North Carolina has also partnered with the Indian Health Services organization to find ways to ensure more equitable access to care and ensure people who are eligible for Medicaid and Health Choice, complete applications and gain access to needed care.

10. What are you doing to continually make progress towards your goal?

North Carolina has still continued to conduct targeted outreach to these communities, and has also continued work with the goal of increasing Health Equity for all North Carolinians. North Carolina has also partnered with the Indian Health Services organization to find ways to ensure more equitable access to care and ensure people who are eligible for Medicaid and Health Choice, complete applications and gain access to needed care. NC Medicaid has also implemented Medicaid Expansion for CHIP, expanding Medicaid eligibility for children in NC to 211% above FPL, essentially merging the SCHIP program with Medicaid, in an effort to expand eligibility to services for children. North Carolina is also working to educate providers and looking at opportunities to provide assistance and incentives to decrease these disparities in health equity and access to care.

11. Anything else you'd like to tell us about this goal?

N/A

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

NC Medicaid has reviewed annual surveys, enrollment data eligibility data, and the U.S Census to collect data on the number of uninsured children in NC, to try to improve this number/ percentage. NC Medicaid has also implemented Medicaid Expansion for CHIP, expanding Medicaid eligibility for children in NC to 211% above FPL, essentially merging the SCHIP program with Medicaid, in an effort to expand eligibility to services for children.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will these data become available?

NC Medicaid has reviewed annual surveys, enrollment data eligibility data, and the U.S Census to collect data on the number of uninsured children in NC, to try to improve this number/ percentage. NC Medicaid has also implemented Medicaid Expansion for CHIP, expanding Medicaid eligibility for children in NC to 211% above FPL, essentially merging the SCHIP program with Medicaid, in an effort to expand eligibility to services for children.

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, behavioral health services access, health care equity, special health care needs, or other emerging health care needs.) What have you discovered through this research?

NC Medicaid has researched disparities and health equity between races, and has found that there was a substantial variation across races and ethnicity groups, in the reported health of children. The largest disparity was in the Alaskan Indian/ Alaskan native group, showing a much larger presentation of poor mental health than all the other races. We also found that providers were less likely to offer telehealth services to children, which as we know could assist some people with accessing care in spite of barriers, such as transportation or living in rural areas.

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Tell us how much you spent on your CHIP program in FFY 2022, and how much you anticipate spending in FFY 2023 and 2024.

Part 1: Benefit Costs

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 637,622,769	**$** 637,622,769	**$** 637,622,769

2. How much did you spend on Fee for Service in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 111,395,594	**$** 111,395,594	**$** 111,395,594

3. How much did you spend on anything else related to benefit costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	$	$

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	$	$

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2022	FFY 2023	FFY 2024
Managed Care	637622769	637622769	637622769
Fee for Service	111395594	111395594	111395594
Other benefit costs			
Cost sharing payments from beneficiaries			
Total benefit costs	749018363	749018363	749018363

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?
This includes wages, salaries, and other employee costs.

2022	2023	2024
$ 4,935,944	**$** 4,935,944	**$** 4,935,944

2. How much did you spend on general administration in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 8,010,963	**$** 8,010,963	**$** 8,010,963

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

4. How much did you spend on claims processing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 325,710	**$** 325,710	**$** 325,710

5. How much did you spend on outreach and marketing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 786,461	**$** 786,461	**$** 786,461

7. How much did you spend on anything else related to administrative costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2022	FFY 2023	FFY 2024
Personnel	4935944	4935944	4935944
General administration	8010963	8010963	8010963
Contractors and brokers			
Claims processing	325710	325710	325710
Outreach and marketing			
Health Services Initiatives (HSI)	786461	786461	786461
Other administrative costs			
Total administrative costs	14059078	14059078	14059078
10% administrative cap	Not Available	83224262.56	83224262.56

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2022	**FFY 2023**	**FFY 2024**
Total program costs	Not Available	763077441	763077441
eFMAP	77.36	77.4	77.36
Federal share	Not Available	590621939.33	590316708.36
State share	Not Available	172455501.67	172760732.64

8. What were your state funding sources in FFY 2022?
Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a managed care delivery system.

1. How many children were eligible for managed care in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 273,025	**$** 273,025	**$** 273,025

2. What was your per member per month (PMPM) cost based on the number of children eligible for managed care in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 195	**$** 195	**$** 195

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	195	195	195

Part 4: Fee for Service Costs

Complete this section only if you have a fee for service delivery system.

1. How many children were eligible for fee for service in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 14,704	**$** 14,704	**$** 14,704

2. What was your per member per month (PMPM) cost based on the number of children eligible for fee for service in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 631	**$** 631	**$** 631

	FFY 2022	**FFY 2023**	**FFY 2024**
PMPM cost	631	631	631

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

N/A

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

The North Carolina General Assembly continues to remain supportive of the CHIP program and agreed to Medicaid Expansion for Children, essentially merging the SCHIP Program with the NC Medicaid program, expanding services to current beneficiaries, and expanding eligibility to Medicaid for children to 211% above FPL.

2. What's the greatest challenge your CHIP program has faced in FFY 2022?

The greatest challenge that the NC Health Choice program experienced was continuing to implement an enormous amount of COVID-19 related services to ensure North Carolinians had access to all Medicaid and NC Health Choice services during the pandemic. In addition, the Department is continuing to aggressively addressing opioid addiction throughout the state, with Medicaid introducing tactics to reduce the oversupply of prescription opioids, the diversion of prescription drugs, and increasing community awareness and prevention.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2022?

The State of North Carolina met several key milestones in FFY 2022, one of those including the Expansion of Medicaid for children, essentially merging the SCHIP program with the Medicaid program, expanding services for all CHIP beneficiaries, and expanding eligibility requirements to 211% above FPL. North Carolina also launched Managed Care in July 2021, and has been working with and monitoring the plans to ensure continuity of care for beneficiaries and highest standards of care. North Carolina is continuing to improve our consumer-directed care model to provide families and beneficiaries with greater flexibility and autonomy to obtain services within managed care and in home-and community-based care.

4. What changes have you made to your CHIP program in FFY 2022 or plan to make in FFY 2023? Why have you decided to make these changes?

As previously stated, the North Carolina General Assembly agreed to Medicaid Expansion for Children, essentially merging the SCHIP Program with the NC Medicaid program, expanding services to current beneficiaries, and expanding eligibility to Medicaid for children to 211% above FPL as of April 1, 2023. We also have the upcoming Tailored Plan launch in October 2023, and the launch of several new 1915(i) services, in an effort to focus on Behavioral Health.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

N/A

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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