



North Carolina CARTS FY2021 Report

Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the mdct_help@cms.hhs.gov.

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

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

4. Contact name:

Ivy J Jones

5. Job title:

CHIP Program Manager II

6. Email:

ivy.jones@dhhs.nc.gov

7. Full mailing address:

Include city, state, and zip code.

2501 Mail Service Center Raleigh, NC 27699-2501

8. Phone number:

919-527-7680

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 the 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

3a. Indicate the range for premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at

196



FPL ends at

210

Premium starts at

\$



Premium ends at

\$

FPL starts at

141



FPL ends at

210

Premium starts at

\$



Premium ends at

\$

FPL starts at

107



FPL ends at

133

Premium starts at

\$



Premium ends at

\$



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.

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 Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Can receive PCCM or FFS

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

133



FPL ends at

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.

Can receive PCCM and FFS

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. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

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 women?

☐ 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. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

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 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 your Pregnant Women State Plan expansion?
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 women?

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

- ☐ Yes
- ☒ No

21. 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.

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 2020 | Number of children enrolled in FFY 2021 | Percent change |
|------------------------------------|--|--|-----------------------|
| Medicaid Expansion CHIP | 55,378 | 208,973 | 277.357% |
| Separate CHIP | 59,520 | 96,673 | 62.421% |

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

The increase in CHIP enrollment, The State reviewed changes in CHIP Enrollment are 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 recipients 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 2020 children's uninsurance rates are currently unavailable. Please skip to Question 3.

| Year | Number of uninsured children | Margin of error | Percent of uninsured children (of total children in your state) | Margin of error |
|-------------|-------------------------------------|------------------------|--|------------------------|
| 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 |

| |
|---|
| Percent change between 2019 and 2020 |
| Not Available |

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

The increase in CHIP enrollment, The State reviewed changes in CHIP Enrollment are 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 recipients 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.

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.

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Program Outreach

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

☒ Yes

1a. What are you doing differently?

The outreach team (comprised of the Minority Outreach Coordinator, Help Line Coordinator and the CYSHCN Access to Care Specialist) traditionally targets 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 Practices 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. During FFY 20-21 the outreach team experienced two adjacent vacancies in key positions requiring work to be maintained by other staff until filled. In August 2021, a new Minority Health Coordinator joined the team after an eight-month vacancy. Her expertise in eligibility determination and Family and Children's Medicaid policy and procedure, along with her lived experience, helped to identify improvements for promotional materials and presentation development. She also began networking with state and local service agencies and shadowing the CYSHCN Help Line coordinator in meetings and presentations to deepen her knowledge and expertise about NC's children's health insurance resources. The retirement of the CYSHCN Access to Care Specialist created another vacancy on the Outreach Team in July 2021. Meticulous recruiting efforts were made by the Best Practices Unit manager to fill this position with the intent of bringing the outreach team to full capacity and being poised for successful outcomes in FFY 21-22. We look forward to building on the momentum this new team brings to our outreach efforts. Despite the staffing changes, and the travel restrictions and social distancing required as a result of COVID19, many outreach efforts were maintained through virtual methods. Outreach staff increased their proportion of virtual presentations and collaborations in the absence of face-to-face activities or events. Outreach staff developed revised strategies to continue promoting the value of NC Medicaid/Health Choice. Staff reached out to various stakeholder organizations or agencies to participate and present in their virtual community meetings. Examples include: refugee stakeholder meetings, including immigration updates associated with new federal administration, Local Interagency

Coordinating Councils, military families, emergency preparation for vulnerable populations, and transition/medical home for special populations (foster care youth). A total of 115 outreach activities occurred in FFY 20-21 [Table 1], impacting over 2,725 participants. During the pandemic travel curtailment, outreach staff also prepared information packets which were mailed to site contacts for inclusion in their distribution efforts (ex. food distribution to rural or Latino populations, back to school events). A total of 1,283 English/Spanish NC Medicaid/NC Health Choice informational flyers were distributed in FFY 20-21. The shift to an online atmosphere required by the pandemic led the team to review and insure current resources were posted and easily accessible on the DPH children with special health needs webpage <https://publichealth.nc.gov/wch/families/cyshcn.htm> and the Medicaid outreach webpage <https://publichealth.nc.gov/wch/families/hchcoutreach.htm>. During FFY 20-21, the Help Line Coordinator oversaw many additions and updates including the Medicaid/Health Choice information, links for CMARC, emergency preparedness webinars and flyers, and COVID19 resources. Revised materials reflect family-driven development and convey messaging in a more family-centered approach.

☐ 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?

The outreach team (comprised of the Minority Outreach Coordinator, Help Line Coordinator and the CYSHCN Access to Care Specialist) traditionally targets 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 Practices 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. During FFY 20-21 the outreach team experienced two adjacent vacancies in key positions requiring work to be maintained by other staff until filled. In August 2021, a new Minority Health Coordinator joined the team after an eight-month vacancy. Her expertise in eligibility determination and Family and Children's Medicaid policy and procedure, along with her lived experience, helped to identify improvements for promotional materials and presentation development. She also began networking with state and local service agencies and shadowing the CYSHCN Help Line coordinator in meetings and presentations to deepen her knowledge and expertise about NC's children's health insurance resources. The retirement of the CYSHCN Access to Care Specialist created another vacancy on the Outreach Team in July 2021. Meticulous recruiting efforts were made by the Best Practices Unit manager to fill this position with the intent of bringing the outreach team to full capacity and being poised for successful outcomes in FFY 21-22. We look forward to building on the momentum this new team brings to our outreach efforts. Despite the staffing changes, and the travel restrictions and social distancing required as a result of COVID19, many outreach efforts were maintained through virtual methods. Outreach staff increased their proportion of virtual presentations and collaborations in the absence of face-to-face activities or events. Outreach staff developed revised strategies to continue promoting the value of NC Medicaid/Health Choice. Staff reached out to various stakeholder organizations or agencies to participate and present in their virtual community meetings. Examples include: refugee stakeholder meetings, including immigration updates

associated with new federal administration, Local Interagency Coordinating Councils, military families, emergency preparation for vulnerable populations, and transition/medical home for special populations (foster care youth). A total of 115 outreach activities occurred in FFY 20-21 [Table 1], impacting over 2,725 participants. During the pandemic travel curtailment, outreach staff also prepared information packets which were mailed to site contacts for inclusion in their distribution efforts (ex. food distribution to rural or Latino populations, back to school events). A total of 1,283 English/Spanish NC Medicaid/NC Health Choice informational flyers were distributed in FFY 20-21. The shift to an online atmosphere required by the pandemic led the team to review and insure current resources were posted and easily accessible on the DPH children with special health needs webpage <https://publichealth.nc.gov/wch/families/cyshcn.htm> and the Medicaid outreach webpage <https://publichealth.nc.gov/wch/families/hchcoutreach.htm>. During FFY 20-21, the Help Line Coordinator oversaw many additions and updates including the Medicaid/Health Choice information, links for CMARC, emergency preparedness webinars and flyers, and COVID19 resources. Revised materials reflect family-driven development and convey messaging in a more family-centered approach.

☐ No

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

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

In NC, the pandemic highlighted the need and led to increased internet connectivity options in rural, low-resource communities allowing us to expand our virtual reach to these communities. Removing time and cost barriers associated with travel led to a participation surge in presentations. Using an online platform, the outreach team was able to exponentially increase the number of presentations targeting uninsured children from 14 (FFY 19-20) to 40 (FFY 20-21) reaching over 500 attendees. The outreach team continues to consider innovative ways to capitalize on the virtual environment and adapt outreach strategies as the landscape evolves.

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 (66% in FFY 20-21). Eighty-two (82%) percent of callers requested resources to access community supports, medical or health care services applicable to their child's reported needs. Seventy-three percent (73%) of callers represent families/caregivers. Ninety-eight percent (98%) of responding callers report the helpfulness and how well their questions were addressed. Further, 89% callers reported they would use the Help Line again or refer others for use. Family partners attended the CSHCN Commission's two subcommittees - Behavioral Health and Oral Health. These groups provided valuable feedback and recommendations to the outreach team on services or policies impacting Medicaid populations. 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, NC Child, NC Justice, NC Budget & Tax Center, Community Care of North Carolina, Family Resource Center South Atlantic, and the NC Partnership for Children. Coalition meeting topics have included: rich discussion on NC's Medicaid transformation, the Child Tax Credit, and legislative updates on Build Back Better. The outreach team, in collaboration with the Family Liaison Specialist and Pediatric Medical Consultant, began development of a training cadre to explain the medical home constructs targeting families of children with all abilities. The training will incorporate AAP elements of a medical home and how parents can build and maintain a successful partnership with their child's health provider, along with empowering their child to be comfortable in eventual ownership of their health care, including transition to adult health care. Plans include engaging youth to provide input. Additionally, the outreach team promotes a dental home for children with special needs developed in cooperation with the NC Commission on Children with Special Needs and the Division of Public Health's Children and Youth Branch. The initiative includes two trainings targeting

dental providers and families addressing how a dental home is as beneficial as a medical home, in addition to dental care accommodations for special needs children. In FFY 20-21, there were 18 "Dental Home for Children and Youth with Special Health Care Needs" [targeting dental providers] presentations and 17 "Dental Home Partnership Strategies for Success" [targeting families]. The family focused presentation also includes detailed information about the Help Line and DPH's CYSHCN website as resources. All presentations continued in a virtual format with a total of 489 participants. The expansion of the dental home training for serving Hispanic populations was explored and plans are under discussion.

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.

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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 data?

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).

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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?

This question should only be answered in respect to Separate CHIP.

☐ Yes

☒ 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 conducts full exparte renewals, utilizing agency records, other programs and all available electronic sources to avoid making any contact with the household to determine continued eligibility.

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

Exparte renewals

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

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

No

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2021?

Don't include applicants being considered for redetermination - this data will be collected in Part 3.

1144

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.

636

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.

498

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 this 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 | 55.59% |
| Denied for eligibility reasons | 43.53% |
| Denials for other reasons | 0.87% |

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 2021?

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

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

43304

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.

417

4a. How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

61

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.

49

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

307

5. Did you have any limitations in collecting this 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 | 99.05% |
| Children disenrolled after redetermination | 0.95% |

Table: Disenrollment in CHIP after Redetermination

| | Percent |
|---|---------|
| Children disenrolled after redetermination | 100% |
| Children disenrolled for procedural reasons | 14.63% |
| Children disenrolled for eligibility reasons | 11.75% |
| Children disenrolled for other reasons | 73.62% |

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 2021?

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

509875

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

464400

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.

480

4a. How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

111

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.

240

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

129

5. Did you have any limitations in collecting this 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 | 91.08% |
| Children disenrolled after redetermination | 0.9% |

Table: Disenrollment in Medicaid after Redetermination

| | Percent |
|---|---------|
| Children disenrolled after redetermination | 100% |
| Children disenrolled for procedural reasons | 23.13% |
| Children disenrolled for eligibility reasons | 50% |
| Children disenrolled for other reasons | 26.88% |

Part 5: Tracking a CHIP cohort (Title XXI) 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 2020 (the second quarter of FFY 2020). 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 last year you reported on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). This year you'll report on the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). 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 2020. 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 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

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 2020 weren't enrolled in CHIP in December 2019.

☐ 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 2020 weren't enrolled in CHIP or Medicaid in December 2019.

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 2020 (start of the cohort): included in 2020 report.

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

3. How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

1871

10319

15095

4643

July - September 2020 (6 months later): included in 2020 report.

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

1748

9639

14292

4419

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

<11

44

82

19

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

<11

12

<11

<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

120

636

721

205

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

93

475

500

131

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

No

January - March 2021 (12 months later): to be completed this year.
This year, please 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

19

2423

3950

1462

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

<11

38

91

25

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

<11

16

28

<11

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

1850

7858

11054

3156

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

298

1581

2003

588

July - September of 2021 (18 months later): to be completed this year
This year, please 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

1147

Ages 1-5

6626

Ages 6-12

10163

Ages 13-16

3215

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

Ages 0-1

49

Ages 1-5

299

Ages 6-12

259

Ages 13-16

65

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

46

Ages 1-5

251

Ages 6-12

165

Ages 13-16

35

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

675

Ages 1-5

3394

Ages 6-12

4673

Ages 13-16

1363

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

615

Ages 1-5

3086

Ages 6-12

4241

Ages 13-16

1240

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

No

Part 6: Tracking a Medicaid (Title XIX) 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 2020 (the second quarter of FFY 2020). 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 last year you reported the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). This year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). 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 2021. 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 2021 must be born after January 2004. Similarly, children who are newly enrolled in February 2021 must be born after February 2004, and children newly enrolled in March 2021 must be born after March 2004.

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 2020 weren't enrolled in Medicaid in December 2019.

☐ 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 2020 weren't enrolled in CHIP or Medicaid in December 2019.

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 2020 (start of the cohort): included in 2020 report

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

3. How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

18723

15742

17868

7581

July - September 2020 (6 months later): included in 2020 report

You completed this section in your 2020 CARTS report. Please refer to that report to assist in filling out this section if needed.

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

18290

14802

16855

7186

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

47

113

178

65

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

30

79

27

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

386

827

835

330

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

68

416

447

159

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

N/A

January - March 2021 (12 months later): to be completed this year
This year, please 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

5190

3902

4851

2049

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

54

123

142

38

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

52

53

13

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

13479

11717

12875

5494

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

539

1038

992

396

July - September of 2021 (18 months later): to be completed next year
This year, please 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

15792

Ages 1-5

12560

Ages 6-12

14769

Ages 13-16

6320

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

Ages 0-1

249

Ages 1-5

456

Ages 6-12

440

Ages 13-16

175

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

124

Ages 1-5

270

Ages 6-12

260

Ages 13-16

101

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

2682

Ages 1-5

2726

Ages 6-12

2659

Ages 13-16

1086

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

1752

Ages 1-5

1688

Ages 6-12

1652

Ages 13-16

673

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

No

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 2021?

0

7. How many cases have been found in favor of the beneficiary in FFY 2021?

0

8. How many cases related to provider credentialing were investigated in FFY 2021?

69

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2021?

7

10. How many cases related to provider billing were investigated in FFY 2021?

641

11. How many cases were referred to appropriate law enforcement officials in FFY 2021?

40

12. How many cases related to beneficiary eligibility were investigated in FFY 2021?

2053

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2021?

<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?

NC Medicaid staff are responsible for prevention, investigation and referral of fraud and abuse case. Provider credentialing is completed within MMIS. Vendors support the work of State staff through provider prepayment and post payment audits as a response to allegations of fraud, waste, and abuse. Vendor responsibilities, processes and protocols are detailed in state contracts. Quality assurance activities and monitoring of the contracted vendors are performed by State staff by looking at contractor deliverables. Corrective Action Plans (CAPs) are required when contract performance standards are not met. Quality Assurance activities on contract deliverables are performed by State staff. North Carolina does not utilize managed care health plans or third-party contractors to provide oversight of vendors. The Division of Health Benefits has oversight responsibilities for seven (7) 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).

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 2021?

Ages 0-1

0

Ages 1-2

<11

Ages 3-5

11

Ages 6-9

24971

Ages
10-14

49518

Ages
15-18

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 2021?

Ages 0-1

0

Ages 1-2

0

Ages 3-5

<11

Ages 6-9

16227

Ages
10-14

31407

Ages
15-18

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 2021?

| 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 2021?

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 2021?

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 2021 CARTS report, we highly encourage states to report all raw CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database instead of reporting a summary of the data via CARTS. For 2022, the only option for reporting CAHPS results will be through the submission of raw data to ARHQ.

1. Did you collect the CAHPS survey?

☐ Yes

☒ No

Part 2: You collected the CAHPS survey

Part 3: You didn't collect the CAHPS survey

Since you didn't collect the CAHPS survey, please complete Part 3.

1. Why didn't you collect the CAHPS survey?

Check all that apply.

- ☐ Entire population wasn't included in the survey
- ☐ Part of the population wasn't included in the survey
- ☐ Data wasn't available due to budget constraints
- ☐ Data wasn't available due to staff constraints
- ☐ Data wasn't consistent or accurate
- ☐ Data source wasn't easily accessible
- ☐ Data source wasn't easily accessible: requires medical records
- ☐ Data source wasn't easily accessible: requires data linkage that doesn't currently exist
- ☐ Data wasn't collected by a provider
- ☐ Sample size was too small (fewer than 30)
- ☒ Other

2. Explain in more detail why you weren't able to collect the CAHPS survey.

CAHPS was not conducted for NC Health Choice in 2021. NC opted to include only Medicaid Beneficiaries and added supplemental questions related to beneficiary experience with telehealth during the COVID-19 pandemic. Of note, no CAHPS survey was initiated in 2021.

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section. States can use up to 10% 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.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1. Does your state operate Health Service 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. Reach out and read is not currently being operated.

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 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. See below for a summary of the quality measures to date and Figure 1 for additional details: • The immunization rate for children ages 0-5 who participated in the program was 41.26%, compared to 36.16% in NC Medicaid overall. • The well-child visit rate for children in the first 30 months of life who participated in the program was 68.18%, compared to 66.38% in NC Medicaid overall. • The well-child visit rate for children 3-5 who participated in the program was 49.17%, compared to 45.62% in NC Medicaid overall. • Data is not yet available for depression screenings between participants and non-participants of the ROR program. Note: This project was largely implemented in 2021. The 2020 data serves to establish a baseline, and further data and analysis of impact will come in the future. Measure Descriptions Childhood Immunization Status (Combination 10): The percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two

or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. Child and Adolescent Well-Care Visits: Assesses children 3-21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. Well-Child Visits in the First 30 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life. Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months.

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

Measure Descriptions Childhood Immunization Status (Combination 10): The percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. Child and Adolescent Well-Care Visits: Assesses children 3-21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. Well-Child Visits in the First 30 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life. Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months.

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 this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

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

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 number of children enrolled in CHIP in the last federal fiscal year.

4. Numerator (total number)

116245

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

The estimated number of uninsured children in North Carolina State during 2021

6. Denominator (total number)

115500

Computed: 100.65%

7. What is the date range of your data?

Start

mm/yyyy

01

/

2021

End

mm/yyyy

12

/

2021

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 Medicaid has continued their outreach to communities, especially rural communities, with less access to care due to lack of providers or distance to care. North Carolina has begun to make progress towards this goal, conducting outreach and providing education, to beneficiaries, as well as working towards ensuring more equitable access to health care for all NC residents in need.

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

North Carolina Medicaid has continued their outreach to communities, especially rural communities, with less access to care due to lack of providers or distance to care. North Carolina has begun to make progress towards this goal, conducting outreach and providing education, to beneficiaries, as well as working towards ensuring more equitable access to health care for all NC residents in need.

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

No

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 the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increase Access to Care

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

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 who visited a primary care physician in the last federal fiscal year.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

 /

End

mm/yyyy

 /

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?

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

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

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).

Do you have another Goal in this list?

Optional



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

You can edit the suggested objective to match what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

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 who received one or more well child visits in the last federal fiscal year.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

 /

End

mm/yyyy

 /

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?

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

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

12. Do you have any supporting documentation?

Optional

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Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

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For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

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- ☐ 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 who received one or more well child visits in the last federal fiscal year.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

 /

End

mm/yyyy

 /

8. Which data source did you use?

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Optional

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Do you have another Goal in this list?

Optional

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

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- ☐ Continuing goal
- ☐ Discontinued goal

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4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

 /

End

mm/yyyy

 /

8. Which data source did you use?

- ☐ Eligibility or enrollment data
- ☐ Survey data
- ☐ Another data source

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

12. Do you have any supporting documentation?

Optional

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Browse...

Do you have another Goal in this list?

Optional

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1. Briefly describe your goal for this objective.

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Define the numerator you're measuring

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4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

 /

End

mm/yyyy

 /

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?

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

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

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.

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Do you have another Goal in this list?

Optional

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

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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?

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

 /

End

mm/yyyy

 /

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?

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

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?

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 this data become available?

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

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).

Tell us how much you spent on your CHIP program in FFY 2021, and how much you anticipate spending in FFY 2022 and 2023.

Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

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 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 236,879,198

\$ 236,879,198

\$ 236,879,198

2. How much did you spend on Fee for Service in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 436,341,742

\$ 436,341,742

\$ 436,341,742

3. How much did you spend on anything else related to benefit costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

\$ 0

2022

\$ 0

2023

\$ 0

Table 1: Benefits Costs

This table is auto-populated with the data you entered above.

| | FFY 2021 | FFY 2022 | FFY 2023 |
|---|-----------|-----------|-----------|
| Managed Care | 236879198 | 236879198 | 236879198 |
| Fee for Service | 436341742 | 436341742 | 436341742 |
| Other benefit costs | 0 | 0 | 0 |
| Cost sharing payments from beneficiaries | 0 | 0 | 0 |
| Total benefit costs | 673220940 | 673220940 | 673220940 |

Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1. How much did you spend on personnel in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

This includes wages, salaries, and other employee costs.

2021

2022

2023

\$ 6,063,607

\$ 6,063,607

\$ 6,063,607

2. How much did you spend on general administration in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 9,202,142

\$ 9,202,142

\$ 9,202,142

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

4. How much did you spend on claims processing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 981,309

\$ 981,309

\$ 981,309

5. How much did you spend on outreach and marketing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 1,101,000

\$ 1,101,000

\$ 1,101,000

7. How much did you spend on anything else related to administrative costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

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 2021 | FFY 2022 | FFY 2023 |
|--|-------------|-------------|-------------|
| Personnel | 6063607 | 6063607 | 6063607 |
| General administration | 9202142 | 9202142 | 9202142 |
| Contractors and brokers | 0 | 0 | 0 |
| Claims processing | 981309 | 981309 | 981309 |
| Outreach and marketing | 0 | 0 | 0 |
| Health Services Initiatives (HSI) | 1101000 | 1101000 | 1101000 |
| Other administrative costs | 0 | 0 | 0 |
| Total administrative costs | 17348058 | 17348058 | 17348058 |
| 10% administrative cap | 74802326.67 | 74802326.67 | 74802326.67 |

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 2023 will be calculated once the eFMAP rate for 2023 becomes available. In the meantime, these values will be blank.

| FMAP Table | FFY 2021 | FFY 2022 | FFY 2023 |
|----------------------------|-----------------|-----------------|-----------------|
| Total program costs | 690568998 | 690568998 | 690568998 |
| eFMAP | 77.18 | 77.36 | 77.4 |
| Federal share | 532981152.66 | 534224176.85 | 534500404.45 |
| State share | 157587845.34 | 156344821.15 | 156068593.55 |

8. What were your state funding sources in FFY 2021?

Select all that apply.

☒

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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021

2022

2023

128583

128583

128583

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

Round to the nearest whole number.

2021

2022

2023

\$ 153

\$ 153

\$ 153

| | FFY 2021 | FFY 2022 | FFY 2023 |
|------------------|----------|----------|----------|
| PMPM cost | 153 | 153 | 153 |

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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021

2022

2023

165815

165815

165815

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2021

2022

2023

\$ 219

\$ 219

\$ 219

| | FFY 2021 | FFY 2022 | FFY 2023 |
|-----------|----------|----------|----------|
| PMPM cost | 219 | 219 | 219 |

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

No

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.

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

Throughout the COVID-19 Public Health Emergency, North Carolina was able to ensure coverage was provided to all CHIP beneficiaries with no lapses in coverage.

2. What's the greatest challenge your CHIP program has faced in FFY 2021?

The greatest challenge during FFY 2021 was the COVID-19 Public Health Emergency. While North Carolina was able to ensure there were no lapses in coverage for beneficiaries, many things changed and needed to be reassessed due to the limitations imposed by COVID-9 and the public health emergency. Decisions need to be made quickly to ensure beneficiaries were still able to receive services and continue to be treated during the public health emergency.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2021?

Again, some of the greatest accomplishments would be navigating through the COVID-19 public health emergency and ensuring our beneficiaries didn't have any lapses in coverage throughout the entire public health emergency, and were still able to receive services and continue to be treated while navigating the limitations imposed by the pandemic, including quarantines and adding telehealth services and conducting outreach to encourage people to get vaccinated for COVID-19.

4. What changes have you made to your CHIP program in FFY 2021 or plan to make in FFY 2022? Why have you decided to make these changes?

As of July 1, 2021, NC Medicaid and CHIP have transitioned to Managed Care. Most beneficiaries were transitioned to Standard Plans or Prepaid Health Plans. Some beneficiaries did continue through Fee-for-Service (FFS) if they met the criteria to remain with Medicaid Direct/FFS. During 2022, the launch of NC Medicaid's Tailored Plans will occur, to better assist those with mental health concerns, developmental delays and traumatic brain injuries.

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

No

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...